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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SE3E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00041

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245490**
2.STATE VENDOR OR MEDICAID NO.
(L2) **915525200**

3. NAME AND ADDRESS OF FACILITY
(L3) **OAK HILLS LIVING CENTER**
(L4) **1314 EIGHTH STREET NORTH**
(L5) **NEW ULM, MN** (L6) **56073**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/08/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **94** (L18)

13.Total Certified Beds **94** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	94			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Wendy Buckholz, HFE NE II 06/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/24/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/30/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245490

July 24, 2014

Ms. Candas Schouvieller, Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, Minnesota 56073

Dear Ms. Schouvieller:

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

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

Effective August 15, 2014 the above facility is certified for:

94 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 94 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 24, 2014

Ms. Candas Schouvieller, Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, Minnesota 56073

RE: Project Number S5490024

Dear Ms. Schouvieller:

On May 29, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 15, 2014. 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 July 8, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 22, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 15, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 18, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 15, 2014, effective July 18, 2014 and therefore remedies outlined in our letter to you dated May 29, 2014, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
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
245490	A. Building B. Wing	7/8/2014

Name of Facility	Street Address, City, State, Zip Code
OAK HILLS LIVING CENTER	1314 EIGHTH STREET NORTH NEW ULM, MN 56073

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 **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **06/04/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **06/18/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **06/18/2014**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **06/18/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **06/18/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **05/21/2014**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **05/21/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	KS/kfd	07/24/2014	31767	07/08/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 5/15/2014

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00041	A. Building B. Wing	7/8/2014

Name of Facility	Street Address, City, State, Zip Code
OAK HILLS LIVING CENTER	1314 EIGHTH STREET NORTH NEW ULM, MN 56073

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20265** Reg. # **MN Rule 4658.0085** LSC	**06/04/2014**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	**06/18/2014**	ID Prefix **20895** Reg. # **MN Rule 4658.0525 Subp.** LSC	**06/18/2014**
ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp.** LSC	**05/21/2014**	ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1** LSC	**06/18/2014**	ID Prefix **21685** Reg. # **MN Rule 4658.1415 Subp.** LSC	**05/21/2014**
ID Prefix **21805** Reg. # **MN St. Statute 144.651 Sul** LSC	**06/18/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	07/24/2014	31767	07/08/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/15/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245490	01 - MAIN BUILDING 01	7/22/2014

Name of Facility	Street Address, City, State, Zip Code
OAK HILLS LIVING CENTER	1314 EIGHTH STREET NORTH NEW ULM, MN 56073

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 K0011	07/18/2014	ID Prefix Reg. # NFPA 101 LSC K0050	07/05/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/kfd	Date: 07/23/2014	Signature of Surveyor: 19251	Date: 07/22/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 5/21/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245490	02 - BLDG 2	7/22/2014

Name of Facility	Street Address, City, State, Zip Code
OAK HILLS LIVING CENTER	1314 EIGHTH STREET NORTH NEW ULM, MN 56073

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 K0050	07/05/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	07/24/2014	31767	7/22/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
5/21/2014	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

July 24, 2014

Ms. Candas Schouvieller, Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, MN 56073

Re: Reinspection Results - Project Number S5490024

Dear Ms. Schouvieller:

On July 8, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 8, 2014, with orders received by you on May 29, 2014. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SE3E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00041

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245490**
2.STATE VENDOR OR MEDICAID NO.
(L2) **915525200**

3. NAME AND ADDRESS OF FACILITY
(L3) **OAK HILLS LIVING CENTER**
(L4) **1314 EIGHTH STREET NORTH**
(L5) **NEW ULM, MN** (L6) **56073**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/15/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **94** (L18)

13.Total Certified Beds **94** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	94			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Wendy Buckholz, HFE NE II 06/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/24/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1987
(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
Posted 06/30/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN-24-5490

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 29, 2014

Ms. Candas Schouvieller, Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, Minnesota 56073

RE: Project Number S5490024

Dear Ms. Schouvieller:

On May 15, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. .

This survey found the most serious deficiencies in your facility to be 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. In addition, at the time of the May 15, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5490013 that was found to be unsubstantiated.

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:

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, MN 56258
Office: (507) 537-7158
Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 24, 2014, 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 June 24, 2014 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 August 15, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 15, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245490	A. BUILDING _____ B. WING _____	05/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	**1314 EIGHTH STREET NORTH NEW ULM, MN 56073**

(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. A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint H5490013 was completed. The complaint was not substantiated.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of	F 157		6/4/14

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

Electronically Signed | 06/06/2014

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

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F 157	Continued From page 1 treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to notify the physician and interested family member of injury for 1 of 1 resident (R94) who had pain in the right toe after an incident. Findings include: During interview on 5/13/14 at 9:54 a.m., R94 complained of pain in her right foot from a bruise she said she had received when staff accidentally ran the wheelchair over her right foot. R94 had diagnoses including osteoarthrosis (arthritis), degenerative joint disease (DJD) and generalized pain and takes scheduled extra strength Tylenol and oxycodone. The minimum data set (MDS) dated 2/14/14 indicated that R94 was cognitively intact.	F 157	CORRECTIVE ACTION- AFFECTED RESIDENT: Resident R94 was noted as having her toe run over by a w/c by staff while she was sitting on the side of her bed during the night before 5/6/14. An initial bruise monitoring flow sheet was started on this incident and the Day nurse made a progress note. However, the staff member failed to complete a facility specific risk management report, notify the physician or family member of the incident, nor was the pain concern by the resident passed along to appropriate personnel. On 5/14/14 a proper incident report was eventually placed into facility risk management program and primary care provider was notified of the situation . The resident was also seen by Clinical Nurse Practitioner on 5/15/14 and the	

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F 157	Continued From page 2 During an observation on 5/14/14, at 2:00 p.m. licensed practical nurse (LPN)-A removed R94's sock of the right foot. The right great toe and next two toes were bluish green in color and painful when LPN-A touched the great toe. During an interview on 5/14/14, at 1:15 p.m. LPN-A indicated she was unsure when the incident occurred. LPN-A stated, "She told the day girls it happened at night but she did not report it to me till after lunch". LPN-A confirmed it was not reported to the primary care provider (PCP) and was unable to verify whether the family had been notified, stating "can't recall if I did ". The progress notes dated 5/6/14 and authored by LPN-A, indicated R94 complained of the right foot 'hurting'. Documentation indicated R94 informed LPN-A "her foot was run over by her w/c (wheelchair) when she was sitting on the edge of her bed". Documentation indicated discomfort was noted when the toes was palpated (touched) but had no increased pain with movement of the toe. During an interview on 5/14/14, at 1:45 p.m. the director of nursing (DON) verified he would have expected that the physician would have been notified. The document, Procedure for Incident (Resident) Documentation, indicated the supervisor or staff nurse who observed, discovered or directly involved in the incident complete a report and the medical doctor (MD) and family will be notified.	F 157	resident declined any radiographs. Resident was offered icing of foot four times a day as needed, but indicated she was not interested in this therapy and thought she was doing better and that the toe did not hurt unless it was manipulated. Bruising charting continued until the bruise subsided. The Nurse who originally noted the bruise was educated about the policy and the policy was reviewed to ensure from now on that all documentation including an incident report must be done on any accidents or incidents involving Residents. Further education regarding the proper way to handle resident incidents and accidents will be discussed at an upcoming staff meeting of licensed nurses. During that meeting, there will also be discussion about appropriate follow up with pain control and documentation requirements as outlined in existing OHLC policy. ACTUAL/PROPOSED COMPLETION DATE: June 04, 2014 PERSON(s) RESPONSIBLE FOR CORRECTION/MONITORING: Immediate corrective monitoring and oversight of the resident□s care on 5/14 and 5/15/14 was done by DON. The DON and Staff Development Nurse will be doing the educational offering on incident and accident reporting and appropriate procedures on 6/4/14 Licensed Staff Meeting. A large Policy and Procedure revision will take place summer 2014 to help identify better reporting systems and	

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F 157	Continued From page 3	F 157	practice management.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to treat 1 of 1 resident (R111) in a dignified manner during the dining experience. Findings include: While observing the dining experience on 5/12/14, at 5:30 p.m. it was noted that R111 had a gait belt around her waist throughout the supper meal. During a second observation of the dining experience on 5/14/14, at 12:30 p.m. it was noted that R111 had a gait belt around her waist throughout the noon meal. During an interview on 5/14/14, at 2:00 p.m., R111 verbalized she did not like wearing the gait belt throughout the meals. When R111 was asked if it bothered her emotionally or physically, she stated "I don't like it." R111's quarterly Minimum Data Set (MDS) dated 3/28/14 indicated moderate cognitive impairment. R111's plan of care dated 5/16/2013 indicated	F 241	CORRECTIVE ACTION- AFFECTED RESIDENT: On 5/12 and 5/14/14 it was noted that Resident R111 did not have her Gait Belt removed once reaching her seat at the dining room table. As per facility policy, it states that the gait belt will be removed once resident is sitting. Staff failed to remove the gait belt and also failed to ask the resident if it was okay to leave the gait belt on. On 5/16/14 Nurse Case manager discussed with Resident the reason why the staff member had kept the gait belt on was to avoid injury when the Resident attempts to ambulate away from the table quickly. Resident was agreeable to wearing the gait belt at meals from the 16th on as the Resident felt that this was the safest practice. Resident□s care plan was updated to reflect this. The facility policy was updated to reflect the importance of gaining the permission of the Resident to keep on the gait belt for Residents who may be at risk of falling when getting up quickly. This new policy will be presented at the 6/4/14 and	6/18/14

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F 241	Continued From page 4 R111 is at risk for falls related to gait and balance problem. One of the interventions included indicated the use of adaptive appliances which included a gait belt and to ensure the least restrictive device or appliance used. There was no planned intervention that a gait belt was required throughout meal times. During an interview with the director of nursing (DON) on 5/15/14, at 9:30 a.m. it was indicated that he expected staff to remove the gait belt once they were done using it when possible. A copy of the facility's policy on using a gait belt was requested and received. The policy dated 10/2013 did not specify when to remove the gait belt, but instructed employees that gait belt usage is mandatory for all assistance with the resident during transfers/mobility.	F 241	6/18/14 staff meetings. ACTUAL/PROPOSED COMPLETION DATE: 6/18/14 PERSON(s) RESPONSIBLE FOR CORRECTION/MONITORING: DON and Staff Development updated policy. DON and Staff development will present gait belt policy changes at the 6/4/14 and 6/18/14 meetings.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor and manage pain for 1 of 3 residents (R94) reviewed who experienced pain.	F 309	CORRECTIVE ACTION- AFFECTED RESIDENT: Resident R94 was noted to have the injury 5/6/14 in which a w/c ran over Resident□s foot. Resident is on scheduled pain medication as indicated in	6/18/14

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F 309	Continued From page 5 Findings include: During interview on 5/13/14 at 9:54 a.m., R94 complained of pain in her right foot from a bruise she said she had received when staff accidentally ran the wheelchair over her right foot. R94 stated, " I 'm suffering with that, it hurts". During interview on 5/14/14, at 12:45 p.m. with R94 she stated, "they drove over it with the wheelchair. It hurts to step on it. If I don't lift my toes then it is OK ". R94 denied having any other type of pain. During an observation on 5/14/14 at 12:45, it was noted that R94 propelled the wheelchair in the hallway with her left foot, veered to the right and bumped into the wall and medication cart. R94 had diagnoses including osteoarthrosis (arthritis), degenerative joint disease (DJD) and generalized pain and takes scheduled extra strength Tylenol and oxycodone. The minimum data set (MDS) dated 2/14/14 indicated that R94 was cognitively intact. During an observation on 5/14/14, at 2:00 p.m. licensed practical nurse (LPN)-A removed R94's sock of the right foot. The right great toe and next two toes were bluish green in color and painful when LPN-A touched the great toe. During an interview on 5/14/14, at 1:15 p.m. LPN-A indicated she was unsure when the incident occurred. LPN-A stated, "She told the day girls it happened at night but she did not report it to me till after lunch". LPN-A confirmed it was not reported to the primary care provider (PCP) and was unable to verify whether the family had been notified, stating "can't recall if I	F 309	observation. Resident was seen by Nurse Practitioner on 5/15/14 in which resident refused Ice pack application and also refused any X-Ray of the foot. Comprehensive pain flowsheet was initiated on 5/15/14 for every week on Thursdays, day shift. Code of 12 indicated on TAR, indicating no pain issues noted. Pain interview conducted on 5/16/14 (coinciding with ARD of MDS). R94 answered yes to having pain, describing it as mild. Resident will also f/u again 6/5/14. Staff did fail to inform provider on initial injury notation. Discussion and education of appropriate incident/accident response as well as documentation will be discussed at 6/4/14 and 6/18/14 staff meetings. In future situations, staff will ensure that physician is called. As a side note, a current Quality Initiative is underway involving much of the interdisciplinary team at OHLC to find better ways to document and control pain. This project will continue through the calendar year and will be instrumental in incidents like this. In the interim, better communication and follow up with pain will be discussed at the 6/4 and 6/18/14 staff meetings. ACTUAL/PROPOSED COMPLETION DATE: 6/18/14 PERSON(s) RESPONSIBLE FOR CORRECTION/MONITORING: Case Managers, Charge Nurses, and DON will be responsible to ensure appropriate documentation and follow up with injury	

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F 309	Continued From page 6 did ". The progress notes dated 5/6/14 and authored by LPN-A, indicated R94 complained of the right foot 'hurting'. Documentation indicated R94 informed LPN-A "her foot was run over by her w/c (wheelchair) when she was sitting on the edge of her bed". Documentation indicated discomfort was noted when the toes was palpated (touched) but had no increased pain with movement of the toe. The progress notes titled 'Monitoring of Bruise' dated 5/7/14-5/15/14, indicated the site was monitored daily and included: site, color, pain/tenderness, and shape/pattern. Documentation indicated that R94 had pain/tenderness of the right hallux toe. Progress notes lacked any interventions that were implemented. During an interview on 5/14/14, at 1:45 p.m. the director of nursing (DON) verified he would have expected that the physician would have been notified and that interventions, which included pain monitoring, should have been implemented. During an interview on 5/15/14, at 12:00 p.m. R94 reported she saw the nurse practitioner (NP) and declined an x-ray at the hospital. R94 further indicated a follow-up visit with the NP was scheduled for next week. R94 further confirmed that right toe pain continues when attempts to stand. The document, Procedure for Incident (Resident) Documentation, directs that the supervisor or staff nurse observing, discovering or directly involved in the incident will complete the incident report thoroughly and completely and then communicated to the Case Manager, DON and	F 309	and accidents, including appropriate Risk Management documentation and contacting of providers as well as follow up for any pain issues from the accident.	

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F 309	Continued From page 7 the medical doctor (MD) and family will be notified.	F 309		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide ongoing services to prevent further decrease in range of motion (ROM) in the lower extremities for 1 of 2 residents (R82) reviewed who had limited range of motion. Findings include: R82 was admitted with diagnoses which included Alzheimer's disease, osteoporosis, peripheral vascular disease, and generalized muscle weakness. During record review, the quarterly minimum data set (MDS) assessment dated 2/3/14 indicated R82 was totally dependent on staff with transfers and required extensive assistance with bed mobility, dressing, toilet use, and personal hygiene. The MDS assessment further identified that R82 had functional limitation in ROM with impairment on one side of upper and lower extremities. The contracture risk assessment dated 2/3/14 revealed a score of 13;	F 318	CORRECTIVE ACTION- AFFECTED RESIDENT: As indicated in observations, Resident R82 was going through PT for contractures of lower extremeties where a knee brace was started on the Resident in May 2013 for the left knee. The use of the brace caused abrasions and blistering of the area almost immediately. Because of this, PT had requested the brace be discontinued on 5/29/13 and nurse practitioner be notified of the adverse reaction to the brace or materials associated with the brace. The documentation indicated that once the healing of the abrasions to have the Nurse Practitioner reevaluate the resident for further intervention. On 6/17/13, it was noted that the abrasions had cleared, however, staff failed to request another assessment for the brace from the Nurse practitioner. On 5/22/14, staff requested another PT	6/18/14

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F 318	Continued From page 8 which indicated the higher the score, the greater potential to develop contractures. This assessment indicated that scores higher than 7 should be considered at risk and should be placed on a regular positioning schedule for both bed and chair. Review of the physical therapy (PT) notes revealed R82 received PT services from 4/12/13 - 5/1/13. The PT plan of care dated 4/12/13 indicated R82 had increased muscle tightness in both lower extremities (LE's) affecting knee extension, with the left side affected by increased tone and tightness. Due to the tightness R82 was at risk for contractures. The PT plan of care further indicated: "ROM: R (right) knee extension is lacking 25 degrees of extension and the L (left) knee is lacking 70 degrees of extension initaially [sic]but with prolonged light stretch was able to break tone to 60 degrees lacking." Further review of PT notes dated 4/16/13 revealed a need for a prolonged stretch brace for R82's left knee "as manual stretch will not benefit pt (patient) due to her severe contractures and tone." A DynaPro knee extension brace was purchased for R82. The PT discharge summary dated 5/1/13 indicated R82's current level of function as: "Patient able to extend knee to 50 degrees with knee extension brace." The long term goals were as noted: (1) PT will train the staff in stretching techniques to be implemented daily to prevent contractures of the bilat (bilateral) knees and improve transfers with the EZ stand and (2) Patient will demonstrate bilateral knee extension increased by 25% to prevent joint contractures and improve use of the EZ stand	F 318	evaluation for Resident R82 for upper Extremities and Lower Extremities contractures. It is noted that PT reports that previous requests for Baclofen were denied by Resident□s family member as the family member did not feel this would help resident be more relaxed (muscularly). PT felt like resident could benefit from Baclofen to help decrease muscle tone and allow better stretching for Resident. Resident□s family member did agree to Baclofen treatment on 5/21/14 prior to therapies and resident was started with therapy again. The left knee brace was attempted to be used again with sheep skin covering. The Resident is currently in PT at this time. On 6/4 and 6/18/14 staff meetings, the importance of documentation will be discussed. A discussion with Aegis therapy in improving communication between interdisciplinary team members is happening every Wednesday during Medicare meetings. ACTUAL/PROPOSED COMPLETION DATE: 6/18/14 PERSON(s) RESPONSIBLE FOR CORRECTION/MONITORING: Neighborhood 1 Case Manager, DON, Charge nurse and Aegis Therapies will monitor Resident care and follow up for therapy recommendations.	

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F 318	Continued From page 9	F 318		

transfer method. The discharge summary further indicated: "Patient has tolerated the brace for extended periods of time in supine, sidelying. Therefore, the need for physical therapy is limited and nursing can now take over for the placement of the brace. Nursing staff has been trained in proper donning and doffing of knee brace."

Review of the nursing progress notes dated 5/29/13 at 1:45 p.m. revealed: "Patient noted to have quarter sized abrasion on left knee. Area is reddened. Will iniate [sic] flowsheet to monitor area." The nursing progress note dated 5/29/14 at 2:41 p.m. indicated: "Writer spoke with PT/OT (occupational therapy) regarding residents brace and abrasions. OT stated to put brace on hold and have NP (nurse practitioner) give new order once abrasions healed. Will await abrasion to heal for new orders. Further review of the nursing progress notes dated 6/17/13 indicated: "Dc'd monitoring for skin redness, Resolved. scab is off of knee skin WNL (within normal limits)." R82's record was reviewed further and no follow-up with the NP once the abrasion was healed was found.

During interview on 5/14/14 at 11:24 a.m., R82's spouse/family member (FM)-D stated he had been performing passive range of motion (PROM) to R82's upper extremities (UE's) since she was discharged from therapy [6/17/13]. FM-D confirmed the OT department had provided him with PROM training for R82's UE's but had never been trained to do PROM to her LE's. FM-D stated he was unsure if therapy was providing that service.

During interview on 5/14/14, at 1:15 p.m., nursing assistant (NA)-B stated that PROM to the lower

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F 318	Continued From page 10 extremities had not been performed with R82 for approximately 2-3 months. NA-B confirmed that PROM for R82 was no longer on the NA's assignment sheets and that R82 had not been in therapy for at least that long. During interview on 5/15/14, at 1:02 p.m., NA-A stated that R82 previously wore a knee brace but it wasn't worn very long due to the fact her knee was "so tight". NA-A stated PROM is attempted during dressing but is difficult. NA-A confirmed that routine PROM for R82 had not been the expectation. During interview on 5/15/14 at 1:21 p.m., licensed practical nurse (LPN)-B confirmed that R82 used to utilize a knee brace which was discontinued after a skin issue occurred from the brace. LPN-B was unsure whether any further recommendations by therapy had occurred subsequent to the discontinuation of the knee brace. During interview on 5/15/14 at 2:11 p.m., the director of nursing confirmed there were no further notes and/or recommendations evident from physical therapy after 5/1/13 in the electronic record of R82. The DON verified that after discontinuation of the knee brace no further evaluations and/or follow-up had occurred.	F 318		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329		6/18/14

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F 329	Continued From page 11 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to monitor the potential side effects of a blood thinning medication for 1 of 5 residents (R103) reviewed for unnecessary medications. Findings include: R103 had diagnoses including atrial fibrillation and congestive heart failure (CHF). Review of the physician orders revealed R103 received Coumadin (an anticoagulant medication that thins the blood and increases risk of bruising) 5 mg (milligrams) po (by mouth) daily every Sunday and Tuesday, and Coumadin 7.5 mg po daily every Monday, Wednesday, Friday, and	F 329	CORRECTIVE ACTION- AFFECTED RESIDENT: As indicated in above observation, Resident R 103 care plan had indicated that bruising would be monitored. Facility policy states that any unusual bruising must be annotated in progress notes and a bruise flowsheet will be started for bruises larger than 3cm by 3cm. Investigation indicates that Nursing Assistant states that she reported the bruising on about 5/13/14, but does not remember to which nurse this was reported. An incident reports was placed into Risk Management and bruise monitoring was started subsequently on 5/15/14. Although Resident R103 felt that	

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F 329	Continued From page 12 Saturday. The plan of care (undated) included: "Monitor/document/report any redness, open areas, scratches, cuts bruises to charge nurse", and "Monitor/document/report to MD (medical doctor) PRN (as needed) s/sx (signs/symptoms) of complications..." that included bruising. During observation/interview on 5/12/14 at 6:58 p.m., R103 was observed with a large bruise on the anterior of the left forearm, a nickel size bruise on the anterior aspect of the right wrist, and bruising in the antecubital space of the right and left arm which R103 attributed to a blood draw. During interview on 5/15/14 at 9:43 a.m., licensed practical nurse (LPN)-A stated upon discovery of a noted bruise, it is measured and investigated for the cause and if the bruise is larger than 3 inches or if unable to identify the cause, an incident report is completed. Subsequently, staff monitor the bruise and document on the treatment administration record (TAR) until resolved. LPN-A confirmed there were no bruises currently being monitored for R103. LPN-A stated that R103 bruises easily due to (d/t) taking Coumadin. After observation of R103's bruised areas with the presence of the surveyor, LPN-A confirmed the bilateral bruising to R103's arms should have been reported and monitored. LPN-A further stated that R103 had been to the emergency room (ER) recently which could account for some of the bruises. After LPN-A noted the large bruise on the anterior aspect of R103's left forearm she stated "That's a whopper". During interview on 5/15/14, at 9:52 a.m., nursing assistant (NA)-A confirmed that she had	F 329	the bruises were related to several IV sticks at the ER, it is still policy that such bruising be reported to the immediate supervisor. The Resident denied any pain with the bruising and the bruising has subsided since this incident. Staff will be educated about Communication of resident findings as well as incident and accident reporting and documentation during the 6/4 and 6/18/14 staff meetings. Staff will have policy refreshment during this instruction. ACTUAL/PROPOSED COMPLETION DATE: 6/18/14 PERSON(s) RESPONSIBLE FOR CORRECTION/MONITORING: DON, Staff Development, and Case Managers will be responsible for upholding company policy and procedure. Individual and group educational offerings will happen 6/4 and 6/18/14 and as needed for any subsequent violation or concern.	

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F 329	Continued From page 13 assisted R103 with morning cares and had identified the bruising to R103's arms. She indicated she had reported this to a nurse "2 days ago", although couldn't remember which nurse it had been reported. NA-A further stated that R103 had indicated it was from a blood draw. Review of R103's incident report dated 5/15/14 at 10:30 a.m. included: "Noted bruise antecubital space lt. (left) arm color fading lt (light) green measures 1x1 cm (centimeter). Anterior Lt. lower arm dark grey bruise measures 6.8 x 4 cm. Lt (left) medial forearm bruise measures 1 x 6 cm reddish color. Rt. arm measures 2 x 1.2 cm." No further documentation related to the bruised area was available for review.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain a sanitary environment in the dietary area which had the potential to affect 88 of 88 residents who were served meals from the kitchen.	F 371	CORRECTIVE ACTION- AFFECTED RESIDENT: As indicated in observation, several areas of concern were noted about the cleanliness of certain areas within the kitchen; both F tags 465 and 371 are similar regarding the nature of the	5/21/14

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F 371	Continued From page 14 Findings include: During the initial tour of the dietary area on 5/12/14 at 3:45 p.m. the following observations were made: (1) The Hobart oven and stove in the kitchen food preparation area was observed to have a heavy build-up of dust on their top surfaces. The gas knobs used to regulate fire temperature was observed to be heavily soiled with dust and grease with balls of dust noted under the lip of the control panel. Further, the wheels and frame of the stove and food warmer were noted to be heavily soiled with food debris, dust and grease. (2.) An Echo water filter was observed mounted to the wall by the dishwashing loading area. The filter had a heavy accumulation of dust, fuzzy in appearance, with cobwebs noted on the back and top portion of the bracket and filter. (3.) The primary cooler used for food storage was observed to have excess dust build-up on the cooler fan casing and coolant feed lines. The area was noted to have heavy dust which could be visualized upon entering the cooler. The cooling fan was blowing across multiple food items stored in the cooler. (4.) The large stand mixer in the kitchen food preparation area was inspected and noted to have food debris on the mixer agitator arm, agitator motor, and frame. When first observed the mixer was covered with a plastic garbage bag and the DM stated the mixer was clean. The DM stated the mixer should have been cleaned after each use. During interview with the DM on 5/12/14, at 4:10 p.m. she verified all of the findings. The DM stated she had known there was a problem with	F 371	cause of such deficiencies. These deficiencies are central to lack of follow up and follow through with cleaning lists and ensuring a QA and audit program exist to make sure cleaning happens on a regular basis. On 5/21/14 a dietary staff meeting was held with Dietary Manager and Kitchen Manager in which the cleaning lists were revised to focus on all areas of deficiency as well as any other cleaning requirement to help prevent the spread of food borne illness. The Kitchen Manager will be doing monthly audits of all cleaning lists as well as spot audits throughout the month which will include inspection of areas of deficiency and all other food service areas. This will ensure the adequate cleanliness of all food service areas. Education and/or disciplinary action will be taken (promptly) for any staff who have not completed assigned cleaning tasks or who fail to provide a safe food service area. ACTUAL/PROPOSED COMPLETION DATE: 5/21/14 PERSON(s) RESPONSIBLE FOR CORRECTION/MONITORING: Dietary Manager and Kitchen Manager will be conducting thorough audits of food service areas as well as QA Audits. Educational Offerings will be made for all staff regarding the requirements of cleaning within the food service areas.	

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F 371	Continued From page 15 the cleaning of the kitchen and realized it had not always been completed as scheduled. The DM stated there had been some problems with staffing consistency. During observation of the food preparation and kitchen environment on 5/14/14 at 11:15 a.m. the following findings were again observed: (1.) The top surfaces of the oven and stove continued to have a coating of dust and grease on them. It was evident the stove and oven had been wiped since initial observation but the center and rear surface was missed and continued to be heavily soiled and (2.) The large stand mixer still had brown residue around base of motor assembly between the motor and agitator arm. At 5/14/14 at 1:00 p.m. the DM submitted a copy of the April and May 2014 cleaning schedule. The cleaning schedule had multiple areas of cleaning projects that were not signed off as completed. The DM stated, based on the findings in the kitchen, she believed the cleaning was not being performed as scheduled. On 05/14/14 at 2:12 p.m. during interview with DM she verified the dietary cleaning was a concern for her and she verbalized lack of confidence that the evening shift had complied with the cleaning schedules. The DM verified the identified areas of concern had not been cleaned satisfactorily to provide a sanitary environment for storing, serving and preparing foods.	F 371		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional,	F 465		5/21/14

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F 465	Continued From page 16 sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain a clean and sanitary environment in the dietary area, including the floors, walls and equipment, which had the potential to affect 88 of 88 residents. Findings include: During the initial tour of the dietary area on 5/12/14 at 3:45 p.m. the following observations were made: (1.) The floor drain located in the dishwashing room near the dishwasher was observed to have a build-up of brown substance on the grate and surrounding floor tiles. The periphery of the drain on the floor tiles was coated with a thick white matter. This was located next to the area where the dirty dishes were placed into the dishwasher. The dietary manager (DM) verified there had been problems with the drain for about a month and the floor had been mopped but no deep cleaning had been completed in this area for approximately a month. In addition, there was a heavy buildup of white substance on floor tiles and along the wall extending the entire length of the dishwasher area. This area extended from the soiled area where the dirty dishes were processed to the area on the clean side of the dishwashing area where clean dishes were handled. Underneath the clean side of the dishwasher area, the floor drain also showed heavy buildup of a white and brown substance. (2.) The handwashing sink, located across from	F 465	CORRECTIVE ACTION- AFFECTED RESIDENT: As indicated in observation, several areas of concern were noted about the cleanliness of certain areas within the kitchen; both F tags 465 and 371 are similar regarding the nature of the cause of such deficiencies. These deficiencies are central to lack of follow up and follow through with cleaning lists and ensuring a QA and audit program exist to make sure cleaning happens on a regular basis. On 5/21/14 a dietary staff meeting was held with Dietary Manager and Kitchen Manager in which the cleaning lists were revised to focus on all areas of deficiency as well as any other cleaning requirement to help prevent the spread of food borne illness. The Kitchen Manager will be doing monthly audits of all cleaning lists as well as spot audits throughout the month which will include inspection of areas of deficiency and all other food service areas. This will ensure the adequate cleanliness of all food service areas. Education and/or disciplinary action will be taken (promptly) for any staff who have not completed assigned cleaning tasks or who fail to provide a safe food service area. ACTUAL/PROPOSED COMPLETION	

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F 465	Continued From page 17 the dishwashing area, had a heavy accumulation of a white/brown substance on floor next to this sink and underneath the soap dispenser. A large floor fan was observed blowing air underneath the dishwasher area and was located so it had contact with the floor substance. (3.) The floor grout lines in the entire dishwashing room were filled with a grey and brown substance. The natural color of the grout was noted to be tan in areas where the grout was not soiled. The dietary manager verified the floor was heavily soiled and it was not due to build up from just one day. (4.) The walk-in freezer was noted to have a large football size ice ball formed on the coolant motor and water lines. The freezer contained food in cardboard boxes that were stored directly under the ice ball. (5.) The dry storage room floor was noted to have excess spillage on the tiled floor under the shelf racks. There was evidence that cooking oil and other substances had leaked onto the floor and been left unattended. The DM stated that oil had spilled or dripped onto floor about a month ago and she thought that was what had caused the residue build-up. (6.) A fire alarm strobe light located on the wall outside of the dry storage room was observed to be heavily soiled with dust and cobwebs that were easily visible. During observation of the food preparation and kitchen environment the following morning on 5/14/14 at 11:15 a.m. the findings as noted were again observed: (1.) The dry storage room floor continued to be soiled with white/brown substance built up on the floor underneath the metal shelving where the facility stored cooking oil.	F 465	DATE: 5/21/14 PERSON(s) RESPONSIBLE FOR CORRECTION/MONITORING: Dietary Manager and Kitchen Manager will be conducting thorough audits of food service areas as well as QA Audits. Educational Offerings will be made for all staff regarding the requirements of cleaning within the food service areas.	

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F 465	Continued From page 18 (2.) The fire alarm strobe light on the wall by the dry storage room door remained soiled with a heavy coating of dust and grime; and (3.) Two breaker boxes located on the wall in the kitchen in food preparation area were noted to have heavy build-up of dust and cobwebs on the top and rear portions of both of both. At 5/14/14 at 1:00 p.m. the DM submitted a copy of the April and May 2014 cleaning schedule. The cleaning schedule had multiple areas of cleaning projects that were not signed off as completed. The DM stated, based on the findings in the kitchen, she believed the cleaning was not being performed as scheduled. On 05/14/14 at 2:12 p.m. during interview with DM she verified the dietary cleaning was a concern for her and she verbalized lack of confidence that the evening shift had complied with the cleaning schedules. The DM verified the identified areas of concern had not been cleaned satisfactorily to provide a sanitary environment for storing, serving and preparing foods.	F 465		

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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 FORM CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on May 21, 2014. At the time of this survey, Building 01 of Oak Hills Living Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code, Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/06/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245490	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/21/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	**1314 EIGHTH STREET NORTH** **NEW ULM, MN 56073**

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K 000	Continued From page 1 By E-Mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Oak Hills Living Center was constructed in 1995, is two-stories, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The nursing home is separated from an assisted living facility by a two-hour fire wall with an opening protective consisting of a labeled, self-closing, positive latching, 90-minute fire-rated door assembly. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. All resident rooms are protected with automatic, hard wired, interconnected smoke detectors. The facility has a capacity of 94 beds and had a census of 87 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011	NFPA 101 LIFE SAFETY CODE STANDARD	K 011		7/18/14

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K 011 SS=F	Continued From page 2 If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and interview it was determined that the 2-hour fire barriers are not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1. This deficient practice could allow the products of combustion to travel from one building to another, which could negatively impact all 87 residents in a fire emergency. Findings include: During the facility tour between the hours of 11:30 AM and 3:00 PM on 5/21/2014, it was observed that the 1st floor 2-hour fire barrier wall between the Nursing Home and the Independent Living building had been constructed for a 1-hour fire barrier wall and not a 2-hour fire barrier wall not in accordance with LSC (00) edition section 19.1.1.4.1. The Supervisor of Maintenance verified this finding of the deficient practice at the time of the inspection.	K 011	K11- UPDATED CORRECTIVE ACTION- We are working with a contractor to fix the wall separating the nursing home and HUD Building in Assisted Living to a 2 hour separation wall. This will be completed when we do the remodel of our current assisted living. Completion date will be July 18, 2014. Environmental Services Supervisor will monitor.	
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		7/5/14

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K 050 SS=F	Continued From page 3 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview, it was determined that the facility failed to vary the times for the required number of fire drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 87 patients. Findings include: On facility tour between 11:00 AM and 3:00 PM on 5/21/2014 a review of the available fire drill reports in 2013-2014 revealed that the facility conducted Day-shift fire drills between the hours of 10:23 AM, 9:21 AM, 10:12 AM, 9:07 AM, Night-shift drills between 2:00 AM, 3:00 AM, 2:00 AM, 1:00 AM not at varied times as required by Section 19.7.1.2. This deficient practice was confirmed by the facility 's Maintenance Supervisor.	K 050	K 50- UPDATED CORRECTIVE ACTION- Fire drills will be scheduled and varied throughout all shifts. Completion date was moved back and will be no later than July 5, 2014. Environmental Services Supervisor will be responsible for monitoring and correction of this plan.	

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	245490	A. BUILDING **02 - BLDG 2** B. WING _____	**05/21/2014**

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K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware	K 050		7/5/14

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K 050	Continued From page 2 that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview, it was determined that the facility failed to vary the times for the required number of fire drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 87 patients. Findings include: On facility tour between 11:00 AM and 3:00 PM on 5/21/2014 a review of the available fire drill reports in 2013-2014 revealed that the facility conducted Day-shift fire drills between the hours of 10:23 AM, 9:21 AM, 10:12 AM, 9:07 AM, Night-shift drills between 2:00 AM, 3:00 AM, 2:00 AM, 1:00 AM not at varied times as required by Section 19.7.1.2. This deficient practice was confirmed by the facility 's Maintenance Supervisor.	K 050	K 50- UPDATED CORRECTIVE ACTION- Fire drills will be scheduled and varied throughout all shifts. Completion date was moved back and will be no later than July 5, 2014. Environmental Services Supervisor will be responsible for monitoring and correction of this plan.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
May 29, 2014

Ms. Candas Schouvieller, Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, Minnesota 56073

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5490024

Dear Ms. Schouvieller:

The above facility was surveyed on May 12, 2014 through May 15, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5490013 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00041	A. BUILDING: _____ B. WING _____	05/15/2014

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On May 12th, 13th, 14th, and 15th, 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. In addition, complaint investigation(s) were also completed at the time of the recertification survey. An investigation of complaint H5490013 was completed. The complaint was not substantiated.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form	2 265		

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2 265	Continued From page 3 of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to notify the physician and interested family member of injury for 1 of 1 resident (R94) who had pain in the right toe after an incident. Findings include: During interview on 5/13/14 at 9:54 a.m., R94 complained of pain in her right foot from a bruise she said she had received when staff accidentally ran the wheelchair over her right foot. R94 had diagnoses including osteoarthrosis (arthritis), degenerative joint disease (DJD) and generalized pain and takes scheduled extra strength Tylenol and oxycodone. The minimum data set (MDS) dated 2/14/14 indicated that R94 was cognitively intact. During an observation on 5/14/14, at 2:00 p.m. licensed practical nurse (LPN)-A removed R94's sock of the right foot. The right great toe and next two toes were bluish green in color and painful when LPN-A touched the great toe. During an interview on 5/14/14, at 1:15 p.m. LPN-A indicated she was unsure when the incident occurred. LPN-A stated, "She told the day girls it happened at night but she did not	2 265		

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2 265	Continued From page 4 report it to me till after lunch". LPN-A confirmed it was not reported to the primary care provider (PCP) and was unable to verify whether the family had been notified, stating "can't recall if I did ". The progress notes dated 5/6/14 and authored by LPN-A, indicated R94 complained of the right foot 'hurting'. Documentation indicated R94 informed LPN-A "her foot was run over by her w/c (wheelchair) when she was sitting on the edge of her bed". Documentation indicated discomfort was noted when the toes was palpated (touched) but had no increased pain with movement of the toe. During an interview on 5/14/14, at 1:45 p.m. the director of nursing (DON) verified he would have expected that the physician would have been notified. The document, Procedure for Incident (Resident) Documentation, indicated the supervisor or staff nurse who observed, discovered or directly involved in the incident complete a report and the medical doctor (MD) and family will be notified. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or desigee could work with the medical director to update policies and procedures for when to notify the physician of changes in the resident, and then could educate staff. The DON or designee could also perform audits of resident records to determine if the physician had been notified as appropriate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		

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	00041	A. BUILDING: _____ B. WING _____	05/15/2014

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2 830	Continued From page 5	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor and assess 1 of 3 residents (R94) reviewed who experienced pain. Findings include: During interview on 5/13/14 at 9:54 a.m., R94 complained of pain in her right foot from a bruise she said she had received when staff accidentally ran the wheelchair over her right foot. R94 stated, " I 'm suffering with that, it hurts". During interview on 5/14/14, at 12:45 p.m. with R94 she stated, "they drove over it with the wheelchair. It hurts to step on it. If I don't lift my toes then it is OK ". R94 denied having any other type of pain. During an observation on 5/14/14 at 12:45, it was noted that R94 propelled the wheelchair in the hallway with her left foot, veered	2 830		

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2 830	Continued From page 6 to the right and bumped into the wall and medication cart. R94 had diagnoses including osteoarthrosis (arthritis), degenerative joint disease (DJD) and generalized pain and takes scheduled extra strength Tylenol and oxycodone. The minimum data set (MDS) dated 2/14/14 indicated that R94 was cognitively intact. During an observation on 5/14/14, at 2:00 p.m. licensed practical nurse (LPN)-A removed R94's sock of the right foot. The right great toe and next two toes were bluish green in color and painful when LPN-A touched the great toe. During an interview on 5/14/14, at 1:15 p.m. LPN-A indicated she was unsure when the incident occurred. LPN-A stated, "She told the day girls it happened at night but she did not report it to me till after lunch". LPN-A confirmed it was not reported to the primary care provider (PCP) and was unable to verify whether the family had been notified, stating "can't recall if I did ". The progress notes dated 5/6/14 and authored by LPN-A, indicated R94 complained of the right foot 'hurting'. Documentation indicated R94 informed LPN-A "her foot was run over by her w/c (wheelchair) when she was sitting on the edge of her bed". Documentation indicated discomfort was noted when the toes was palpated (touched) but had no increased pain with movement of the toe. The progress notes titled 'Monitoring of Bruise' dated 5/7/14-5/15/14, indicated the site was monitored daily and included: site, color, pain/tenderness, and shape/pattern. Documentation indicated that R94 had pain/tenderness of the right hallux toe. Progress	2 830		

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2 830	Continued From page 7 notes lacked any interventions that were implemented. During an interview on 5/14/14, at 1:45 p.m. the director of nursing (DON) verified he would have expected that the physician would have been notified and that interventions, which included pain monitoring, should have been implemented. During an interview on 5/15/14, at 12:00 p.m. R94 reported she saw the nurse practitioner (NP) and declined an x-ray at the hospital. R94 further indicated a follow-up visit with the NP was scheduled for next week. R94 further confirmed that right toe pain continues when attempts to stand. The document, Procedure for Incident (Resident) Documentation, directs that the supervisor or staff nurse observing, discovering or directly involved in the incident will complete the incident report thoroughly and completely and then communicated to the Case Manager, DON and the medical doctor (MD) and family will be notified. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review and reeducate all staff on the policies and procedures to ensure that all resident's health issues are properly monitored. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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2 895	Continued From page 8	2 895		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide ongoing services to prevent further decrease in range of motion (ROM) in the lower extremities for 1 of 2 residents (R82) reviewed who had limited range of motion. Findings include: R82 was admitted with diagnoses which included Alzheimer's disease, osteoporosis, peripheral vascular disease, and generalized muscle weakness. During record review, the quarterly minimum data set (MDS) assessment dated 2/3/14 indicated R82 was totally dependent on staff with transfers and required extensive assistance with bed mobility, dressing, toilet use, and personal hygiene. The MDS assessment further identified that R82 had functional limitation in ROM with impairment on one side of upper and	2 895		

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2 895	Continued From page 9 lower extremities. The contracture risk assessment dated 2/3/14 revealed a score of 13; which indicated the higher the score, the greater potential to develop contractures. This assessment indicated that scores higher than 7 should be considered at risk and should be placed on a regular positioning schedule for both bed and chair. Review of the physical therapy (PT) notes revealed R82 received PT services from 4/12/13 - 5/1/13. The PT plan of care dated 4/12/13 indicated R82 had increased muscle tightness in both lower extremities (LE's) affecting knee extension, with the left side affected by increased tone and tightness. Due to the tightness R82 was at risk for contractures. The PT plan of care further indicated: "ROM: R (right) knee extension is lacking 25 degrees of extension and the L (left) knee is lacking 70 degrees of extension initaially [sic]but with prolonged light stretch was able to break tone to 60 degrees lacking." Further review of PT notes dated 4/16/13 revealed a need for a prolonged stretch brace for R82's left knee "as manual stretch will not benefit pt (patient) due to her severe contractures and tone." A DynaPro knee extension brace was purchased for R82. The PT discharge summary dated 5/1/13 indicated R82's current level of function as: "Patient able to extend knee to 50 degrees with knee extension brace." The long term goals were as noted: (1) PT will train the staff in stretching techniques to be implemented daily to prevent contractures of the bilat (bilateral) knees and improve transfers with the EZ stand and (2) Patient will demonstrate bilateral knee extension increased by 25% to prevent joint	2 895		

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2 895	Continued From page 10	2 895		

contractures and improve use of the EZ stand transfer method. The discharge summary further indicated: "Patient has tolerated the brace for extended periods of time in supine, sidelying. Therefore, the need for physical therapy is limited and nursing can now take over for the placement of the brace. Nursing staff has been trained in proper donning and doffing of knee brace."

Review of the nursing progress notes dated 5/29/13 at 1:45 p.m. revealed: "Patient noted to have quarter sized abrasion on left knee. Area is reddened. Will iniate [sic] flowsheet to monitor area." The nursing progress note dated 5/29/14 at 2:41 p.m. indicated: "Writer spoke with PT/OT (occupational therapy) regarding residents brace and abrasions. OT stated to put brace on hold and have NP (nurse practitioner) give new order once abrasions healed. Will await abrasion to heal for new orders. Further review of the nursing progress notes dated 6/17/13 indicated: "Dc'd monitoring for skin redness, Resolved. scab is off of knee skin WNL (within normal limits)." R82's record was reviewed further and no follow-up with the NP once the abrasion was healed was found.

During interview on 5/14/14 at 11:24 a.m., R82's spouse/family member (FM)-D stated he had been performing passive range of motion (PROM) to R82's upper extremities (UE's) since she was discharged from therapy [6/17/13]. FM-D confirmed the OT department had provided him with PROM training for R82's UE's but had never been trained to do PROM to her LE's. FM-D stated he was unsure if therapy was providing that service.

During interview on 5/14/14, at 1:15 p.m., nursing assistant (NA)-B stated that PROM to the lower

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2 895	Continued From page 11	2 895		

extremities had not been performed with R82 for approximately 2-3 months. NA-B confirmed that PROM for R82 was no longer on the NA's assignment sheets and that R82 had not been in therapy for at least that long.

During interview on 5/15/14, at 1:02 p.m., NA-A stated that R82 previously wore a knee brace but it wasn't worn very long due to the fact her knee was "so tight". NA-A stated PROM is attempted during dressing but is difficult. NA-A confirmed that routine PROM for R82 had not been the expectation.

During interview on 5/15/14 at 1:21 p.m., licensed practical nurse (LPN)-B confirmed that R82 used to utilize a knee brace which was discontinued after a skin issue occurred from the brace. LPN-B was unsure whether any further recommendations by therapy had occurred subsequent to the discontinuation of the knee brace.

During interview on 5/15/14 at 2:11 p.m., the director of nursing confirmed there were no further notes and/or recommendations evident from physical therapy after 5/1/13 in the electronic record of R82. The DON verified that after discontinuation of the knee brace no further evaluations and/or follow-up had occurred.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review and revise the policies and procedures for range of motion programs, educate the appropriate personnel in any changes and appoint a designee to monitor the procedures to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

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2 895	Continued From page 12 (21) days.	2 895		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain a sanitary environment in the dietary area which had the potential to affect 88 of 88 residents who were served meals from the kitchen. Findings include: During the initial tour of the dietary area on 5/12/14 at 3:45 p.m. the following observations were made: (1) The Hobart oven and stove in the kitchen food preparation area was observed to have a heavy build-up of dust on their top surfaces. The gas knobs used to regulate fire temperature was observed to be heavily soiled with dust and grease with balls of dust noted under the lip of the control panel. Further, the wheels and frame of the stove and food warmer were noted to be heavily soiled with food debris, dust and grease. (2.) An Echo water filter was observed mounted to the wall by the dishwashing loading area. The filter had a heavy accumulation of dust, fuzzy in appearance, with cobwebs noted on the back and top portion of the bracket and filter.	21015		

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21015	Continued From page 13 (3.) The primary cooler used for food storage was observed to have excess dust build-up on the cooler fan casing and coolant feed lines. The area was noted to have heavy dust which could be visualized upon entering the cooler. The cooling fan was blowing across multiple food items stored in the cooler. (4.) The large stand mixer in the kitchen food preparation area was inspected and noted to have food debris on the mixer agitator arm, agitator motor, and frame. When first observed the mixer was covered with a plastic garbage bag and the DM stated the mixer was clean. The DM stated the mixer should have been cleaned after each use. During interview with the DM on 5/12/14, at 4:10 p.m. she verified all of the findings. The DM stated she had known there was a problem with the cleaning of the kitchen and realized it had not always been completed as scheduled. The DM stated there had been some problems with staffing consistency. During observation of the food preparation and kitchen environment on 5/14/14 at 11:15 a.m. the following findings were again observed: (1.) The top surfaces of the oven and stove continued to have a coating of dust and grease on them. It was evident the stove and oven had been wiped since initial observation but the center and rear surface was missed and continued to be heavily soiled and (2.) The large stand mixer still had brown residue around base of motor assembly between the motor and agitator arm. At 5/14/14 at 1:00 p.m. the DM submitted a copy of the April and May 2014 cleaning schedule. The cleaning schedule had multiple areas of cleaning projects that were not signed off as completed.	21015		

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21015	Continued From page 14 The DM stated, based on the findings in the kitchen, she believed the cleaning was not being performed as scheduled. On 05/14/14 at 2:12 p.m. during interview with DM she verified the dietary cleaning was a concern for her and she verbalized lack of confidence that the evening shift had complied with the cleaning schedules. The DM verified the identified areas of concern had not been cleaned satisfactorily to provide a sanitary environment for storing, serving and preparing foods. SUGGESTED METHOD OF CORRECTION: The administrator with the director of dietary services or designee(s) could review and revise as necessary the policies and procedures regarding kitchen sanitation. The director of dietary or designee (s) could provide training for all appropriate staff on these policies and procedures. The director of dietary or designee (s) could monitor to assure staff are cleaning the kitchen equipment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21015		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or	21535		

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21535	Continued From page 15 discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, document review and interview the facility failed to monitor the potential side effects of a blood thinning medication for 1 of 5 residents (R103) reviewed for unnecessary medications. Findings include: R103 had diagnoses including atrial fibrillation and congestive heart failure (CHF). Review of the physician orders revealed R103 received Coumadin (an anticoagulant medication that thins the blood and increases risk of bruising) 5 mg (milligrams) po (by mouth) daily every Sunday and Tuesday, and Coumadin 7.5 mg po daily every Monday, Wednesday, Friday, and Saturday. The plan of care (undated) included: "Monitor/document/report any redness, open areas, scratches, cuts bruises to charge nurse", and "Monitor/document/report to MD (medical doctor) PRN (as needed) s/sx (signs/symptoms) of complications..." that included bruising.	21535		

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21535	Continued From page 16 During observation/interview on 5/12/14 at 6:58 p.m., R103 was observed with a large bruise on the anterior of the left forearm, a nickel size bruise on the anterior aspect of the right wrist, and bruising in the antecubital space of the right and left arm which R103 attributed to a blood draw. During interview on 5/15/14 at 9:43 a.m., licensed practical nurse (LPN)-A stated upon discovery of a noted bruise, it is measured and investigated for the cause and if the bruise is larger than 3 inches or if unable to identify the cause, an incident report is completed. Subsequently, staff monitor the bruise and document on the treatment administration record (TAR) until resolved. LPN-A confirmed there were no bruises currently being monitored for R103. LPN-A stated that R103 bruises easily due to (d/t) taking Coumadin. After observation of R103's bruised areas with the presence of the surveyor, LPN-A confirmed the bilateral bruising to R103's arms should have been reported and monitored. LPN-A further stated that R103 had been to the emergency room (ER) recently which could account for some of the bruises. After LPN-A noted the large bruise on the anterior aspect of R103's left forearm she stated "That's a whopper". During interview on 5/15/14, at 9:52 a.m., nursing assistant (NA)-A confirmed that she had assisted R103 with morning cares and had identified the bruising to R103's arms. She indicated she had reported this to a nurse "2 days ago", although couldn't remember which nurse it had been reported. NA-A further stated that R103 had indicated it was from a blood draw.	21535		

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21535	Continued From page 17 Review of R103's incident report dated 5/15/14 at 10:30 a.m. included: "Noted bruise antecubital space lt. (left) arm color fading lt (light) green measures 1x1 cm (centimeter). Anterior Lt. lower arm dark grey bruise measures 6.8 x 4 cm. Lt (left) medial forearm bruise measures 1 x 6 cm reddish color. Rt. arm measures 2 x 1.2 cm." No further documentation related to the bruised area was available for review. SUGGESTED METHOD OF CORRECTION: The Director of Nurses could inservice staff regarding the importance of monitoring for the side effects and efficacy of prescribed medications. A tool could be developed for residents who have physician ordered Coumadin so that bruising and other side effects could be assessed and monitored. A quality assurance measure could be developed to report to the overall quality committee the effectiveness of the tool. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21535		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview the facility	21685		

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	00041	A. BUILDING: _____ B. WING _____	05/15/2014

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21685	Continued From page 18 failed to maintain a clean and sanitary environment in the dietary area, including the floors, walls and equipment, which had the potential to affect 88 of 88 residents. Findings include: During the initial tour of the dietary area on 5/12/14 at 3:45 p.m. the following observations were made: (1.) The floor drain located in the dishwashing room near the dishwasher was observed to have a build-up of brown substance on the grate and surrounding floor tiles. The periphery of the drain on the floor tiles was coated with a thick white matter. This was located next to the area where the dirty dishes were placed into the dishwasher. The dietary manager (DM) verified there had been problems with the drain for about a month and the floor had been mopped but no deep cleaning had been completed in this area for approximately a month. In addition, there was a heavy buildup of white substance on floor tiles and along the wall extending the entire length of the dishwasher area. This area extended from the soiled area where the dirty dishes were processed to the area on the clean side of the dishwashing area where clean dishes were handled. Underneath the clean side of the dishwasher area, the floor drain also showed heavy buildup of a white and brown substance. (2.) The handwashing sink, located across from the dishwashing area, had a heavy accumulation of a white/brown substance on floor next to this sink and underneath the soap dispenser. A large floor fan was observed blowing air underneath the dishwasher area and was located so it had contact with the floor substance. (3.) The floor grout lines in the entire dishwashing room were filled with a grey and	21685		

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21685	Continued From page 19	21685		

brown substance. The natural color of the grout was noted to be tan in areas where the grout was not soiled. The dietary manager verified the floor was heavily soiled and it was not due to build up from just one day.
(4.) The walk-in freezer was noted to have a large football size ice ball formed on the coolant motor and water lines. The freezer contained food in cardboard boxes that were stored directly under the ice ball.
(5.) The dry storage room floor was noted to have excess spillage on the tiled floor under the shelf racks. There was evidence that cooking oil and other substances had leaked onto the floor and been left unattended. The DM stated that oil had spilled or dripped onto floor about a month ago and she thought that was what had caused the residue build-up.
(6.) A fire alarm strobe light located on the wall outside of the dry storage room was observed to be heavily soiled with dust and cobwebs that were easily visible.

During observation of the food preparation and kitchen environment the following morning on 5/14/14 at 11:15 a.m. the findings as noted were again observed:
(1.) The dry storage room floor continued to be soiled with white/brown substance built up on the floor underneath the metal shelving where the facility stored cooking oil.
(2.) The fire alarm strobe light on the wall by the dry storage room door remained soiled with a heavy coating of dust and grime; and
(3.) Two breaker boxes located on the wall in the kitchen in food preparation area were noted to have heavy build-up of dust and cobwebs on the top and rear portions of both of both.

At 5/14/14 at 1:00 p.m. the DM submitted a copy

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21685	Continued From page 20 of the April and May 2014 cleaning schedule. The cleaning schedule had multiple areas of cleaning projects that were not signed off as completed. The DM stated, based on the findings in the kitchen, she believed the cleaning was not being performed as scheduled. SUGGESTED METHOD OF CORRECTION: The dietary manager could inservice staff regarding the importance of maintaining the cleaning schedule. An audit could be developed with the assistance of the maintenance staff to assure that floors, walls and equipment be maintained and on a regular schedule. The result of the audit could be reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to treat 1 of 1 resident (R111) in a dignified manner during the dining experience. Findings include:	21805		

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21805	Continued From page 21 While observing the dining experience on 5/12/14, at 5:30 p.m. it was noted that R111 had a gait belt around her waist throughout the supper meal. During a second observation of the dining experience on 5/14/14, at 12:30 p.m. it was noted that R111 had a gait belt around her waist throughout the noon meal. During an interview on 5/14/14, at 2:00 p.m., R111 verbalized she did not like wearing the gait belt throughout the meals. When R111 was asked if it bothered her emotionally or physically, she stated "I don't like it." R111's quarterly Minimum Data Set (MDS) dated 3/28/14 indicated moderate cognitive impairment. R111's plan of care dated 5/16/2013 indicated R111 is at risk for falls related to gait and balance problem. One of the interventions included indicated the use of adaptive appliances which included a gait belt and to ensure the least restrictive device or appliance used. There was no planned intervention that a gait belt was required throughout meal times. During an interview with the director of nursing (DON) on 5/15/14, at 9:30 a.m. it was indicated that he expected staff to remove the gait belt once they were done using it when possible. A copy of the facility's policy on using a gait belt was requested and received. The policy dated 10/2013 did not specify when to remove the gait belt, but instructed employees that gait belt usage is mandatory for all assistance with the resident during transfers/mobility. SUGGESTED METHOD OF CORRECTION:	21805		

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21805	Continued From page 22 The director of nursing or social services could in-service all staff on the need to treat all residents with respect and dignity. The Quality Assessment and Assurance committee could develop a system to audit employees for dignified care and services toward residents in the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		