DEPARTMENT OF HEALTH A						DICARE & MEDICAID SERVICES		
					AND TRANSMITTAL FE SURVEY AGENCY	ID: SE3E Facility ID: 00041		
1. MEDICARE/MEDICAID PROVIDER (L1) 245490 2.STATE VENDOR OR MEDICAID NO. (L2) 915525200		3. NAME AND AI (L3) OAK HILLS (L4) 1314 EIGHT (L5) NEW ULM ,	DDRESS OF FAC S LIVING CE IH STREET N	CILITY NTER	(L6) 56073	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
 5. EFFECTIVE DATE CHANGE OF OW (L9) 6. DATE OF SURVEY 07/08/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other 		7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	DPPLIER CATEC 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	60RY 09 ESRD 10 NF 11 ICF/III 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31		
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	94 (L18) 94 (L17)	Complianc 1. A B. Not in Con		gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A	6. Scope of Services Limit 7. Medical Director		
14. LTC CERTIFIED BED BREAKDOWN	I			1	15. FACILITY MEETS			
18 SNF 18/19 SNF 94	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Wendy Buckholz, HFE			6/06/2014	(L19)	Kamala Fiske-Downing, Enforcement Specialist 06/24/2014 (L20)			
PART	II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY		
 DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Parti <u>2</u>. Facility is not Eligible 			IPLIANCE WITH HTS ACT:	H CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
22. ORIGINAL DATE 2	3. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION 08/01/1987	BEGINNING	G DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure			
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	8		
25. LTC EXTENSION DATE: 2		VE SANCTIONS			03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER		
(L27)	·	n of Admissions: uspension Date:	(L44)			07-Provider Status Change 00-Active		
	D. Resenid 5	uspension Date.	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY			30. REMARKS			
		03001						
	(L28)	-		(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
	(L32)	06/30/2014		(L33)	DETERMINATION APPE	ROVAL		



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,

Kumalu 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



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,

Kumalu 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

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 245490	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 7/8/2014
Name	e of Facility		Street Address, City, State, Zip Code	
OA	AK 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
	F0157 483.10(b)(11)	C	Correction Completed 06/04/2014		F0241 483.15(a)		Correction Completed 06/18/2014		ID Prefix Reg. # LSC	483.25		Correction Completed 06/18/2014
	F0318 483.25(e)(2)	C	Correction Completed 06/18/2014		F0329 483.25(I)		Correction Completed 06/18/2014			F0371 483.35(i)		Correction Completed 05/21/2014
ID Prefix Reg. # LSC	F0465 483.70(h)	0	Correction Completed 15/21/2014	_			Correction Completed		Reg. #			
ID Prefix Reg. # LSC			Correction Completed									
Reg. #			Correction Completed	Deg #					D //			
Reviewed I	By Re	viewed I	Ву	Date:	Signatu	re of Sur	veyor:				Date:	
State Agen	су н	KS/kfd		07/24/20	14		3	1767				07/08/2014
Reviewed I CMS RO	3y Re'	viewed I	Ву	Date:	Signatu	re of Sur					Date:	
Followup t	o Survey Comple 5/15/20 ⁻									Summary of the Facility?	YES	NO

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00041	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 7/8/2014
Name	e 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	(Y	5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix	20265	Correction Completed 06/04/2014	ID Prefix		Correction Completed 06/18/2014	ID Prefix	20895	Correction Completed 06/18/2014
	MN Rule 4658.0085			MN Rule 4658.0520 Sub			MN Rule 4658.0525	
	21015 MN Rule 4658.0610 S						21685 MN Rule 4658.1415	
0	21805 MN St. Statute 144.65		Reg. #			ID Prefix Reg. #		Correction Completed
ID Prefix Reg. # LSC			Reg. #					
ID Prefix Reg. # LSC			Reg. #			ID Prefix Reg. # LSC		
Reviewed E State Agen Reviewed E CMS RO	cy KS/kf	d	Date: 07/24/20 Date:	Signature of Sur	312	767	Date:	07/08/2014
Followup t	o Survey Completed of 5/15/2014 2M: REVISIT REPORT			Check for any Uncor Uncorrected Defic Page 1 of 1				NO

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 245490	(Y2) Multiple Construction A. Building B. Wing 01 - MA	(Y3) Date of Revisit 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	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 07/18/2014	ID Prefix		Correction Completed 07/05/2014	ID Prefix		Correction Completed
-	NFPA 101	-	-	NFPA 101		Reg. #		
LSC	K0011	-	LSC	K0050				
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #		_	Reg. #			Dec #		
		-				LSC		
		Correction			Correction			Correction
ID Drofin		Completed	ID Drofiv		Completed	ID Drofin		Completed
ID Prefix		_						
Reg. # LSC		-	Reg. # LSC			Reg. # LSC		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #					-			
LSC		-	LSC			LSC		
ID Prefix		Correction Completed	ID Prefix		Correction Completed	ID Prefix		Correction Completed
Reg. #			Reg. #			Reg. #		
LSC		-	LSC			LSC		_
Reviewed B	By Reviewed	d By	Date:	Signature of Sur	veyor:		Date:	
State Agen	cy PS/kt	fd	07/23/2	014	19	251		07/22/2014
Reviewed E CMS RO	3y Reviewed	1 Ву	Date:	Signature of Sur	veyor:		Date:	
Followup t	o Survey Completed or 5/21/2014	n:		Check for any Unco Uncorrected Defic		iencies. Was a Su S-2567) Sent to the		NO

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 245490	(Y2) Multiple Construction A. Building B. Wing O2 - BLDG 2	(Y3) Date of Revisit 7/22/2014
Name of Facility	Street Ad	dress, City, State, Zip Code
OAK HILLS LIVING CENTER		EIGHTH STREET NORTH 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		Correction Completed 07/05/2014	ID Prefix		Correction Completed	ID Prefix		Correction Completed
	NFPA 101	_	Reg. #			Reg. #		
LSC	K0050	-	LSC			LSC _		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #		_	Reg. #			D "		
		-				LSC _		
		Correction			Correction			Correction
ID Prefix		Completed	ID Brofix		Completed	ID Brofiv		Completed
		_				D //		
Reg. # LSC		-	Reg. # LSC			Reg. # LSC		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #			Reg. #			Reg. # LSC		
		_						
		Correction Completed			Correction Completed			Correction Completed
ID Prefix		_	ID Prefix		Completed	ID Prefix		
Reg. #		_	Reg. #			Reg. #		
LSC		-						
				1				
Reviewed I	By Reviewed	d By	Date:	Signature of Sur	veyor:		Date:	
State Agen		PS/kfd	07/24/2014		3	1767		7/22/2014
Reviewed I CMS RO	3y Reviewed	d By	Date:	Signature of Sur	veyor:		Date:	
Followup t	o Survey Completed of 5/21/2014	n:	c	heck for any Uncor Uncorrected Defic				NO
			1					



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,

Kumalu 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						DICARE & MEDICAID SERVICES		
					AND TRANSMITTAL TE SURVEY AGENCY	ID: SE3E Facility ID: 00041		
1. MEDICARE/MEDICAID PROVIDE		3. NAME AND AL			IE SURVET AGENCI	-		
(L1) 245490	X NO.	(L3) OAK HILLS						
2.STATE VENDOR OR MEDICAID NO	Э.	(L4) 1314 EIGHT	TH STREET N	ORTH		1. Initial2. Recertification3. Termination4. CHOW		
(L2) 915525200		(L5) NEW ULM, MN			(L6) 56073	5. Validation 6. Complaint 7. On-Site Visit 9. Other		
5. EFFECTIVE DATE CHANGE OF O	WNERSHIP	7. PROVIDER/SU	PPLIER CATEG	ORY	<u>02</u> (L7)	8. Full Survey After Complaint		
(L9)	01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	6. Full Survey Arter Complaint			
	5/2014 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF 11 ICF/III	14 CORF	FISCAL YEAR ENDING DATE: (L35)		
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/III 12 RHC	D 15 ASC 16 HOSPICE	12/31		
2 AOA 3 Other		04 51 12	00 01 1/51	12 1410				
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:				
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:		
To (b):			equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit		
12. Total Facility Beds	94 (L18)		cceptable POC		3. 24 Hour RN7. Medical Director 4. 7-Day RN (Rural SNF)8. Patient Room Size			
	, , , , , , , , , , , , , , , , , , ,		1		5. Life Safety Code	9. Beds/Room		
13.Total Certified Beds	94 (L17)	B. Not in Con Requireme	pliance with Prog ents and/or Appli	gram ed Waivers:	: * Code: B	(L12)		
14. LTC CERTIFIED BED BREAKDOW	VN				15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
94								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION I	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Wendy Buckholz, HFE NE I	I	0	6/06/2014		Kamala Fiske-Downing, Enforcement Specialist 06/24/2014			
				(L19)		(L20)		
PAR	T II - TO BE (COMPLETED	BY HCFA RE	GIONA	L OFFICE OR SINGLE S	TATE AGENCY		
19. DETERMINATION OF ELIGIBILI	ТҮ		IPLIANCE WITH ITS ACT:	I CIVIL		ncial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)		
 Facility is Eligible to Pa 	rticipate	1.001			3. Both of the Above :			
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE	23. LTC AGREEN		4. LTC AGREEN		26. TERMINATION ACTION:			
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	ГЕ	<u>VOLUNTARY</u> <u>00</u>			
08/01/1987					01-Merger, Closure 02-Dissatisfaction W/ Reimburse	05-Fail to Meet Health/Safety ement 06-Fail to Meet Agreement		
(L24)	(L41)		(L25)		03-Risk of Involuntary Terminatio	n		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			04-Other Reason for Withdrawal	07-Provider Status Change		
	A. Suspension	of Admissions.	(L44)			00-Active		
(L27)	B. Rescind Su	spension Date:	. ,					
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)	Posted 06/30/2014	4 CO.		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE				
	(L32)			(L33)	DETERMINATION APPI	ROVAL		

DEPARTMENT OF HEALTH AND HUMAN SERVICES	CENTERS FOR MEDICARE & MEDICAID SERVICES			
MEDICARE/MEDICAID CERTIFICATION AN	D TRANSMITTAL	ID: SE3E		
PART I - TO BE COMPLETED BY THE STATE	SURVEY AGENCY	Facility ID: 00041		

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.



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

Oak Hills Living Center May 29, 2014 Page 3

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

Oak Hills Living Center May 29, 2014 Page 4

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: Oak Hills Living Center May 29, 2014 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

Mr. 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,

Kumalu 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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	<u>MB NO.</u>	. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					X3) DATE SURVEY COMPLETED	
		245490	B. WING			05/	15/2014	
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
ΟΔΚ ΗΙΙ	LS LIVING CENTER				314 EIGHTH STREET NORTH			
				N	EW ULM, MN 56073			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT	ſS	F 0	00				
F 157 SS=D	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of your validate that substar regulations has beet your verification sur complaint investigat the time of the stan An investigation of completed. The co 483.10(b)(11) NOT (INJURY/DECLINE A facility must immer consult with the rest known, notify the re- or an interested fan accident involving the intervention; a significantly (i.e., a existing form of treat	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with vey was conducted and tion(s) were also completed at dard survey. complaint H5490013 was mplaint was not substantiated. IFY OF CHANGES	F 1	57			6/4/14	
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE	
Electron	ically Signed						06/06/2014	

Electronically Signed

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.

PRINTED: 06/09/2014

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/09/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE SURVEY COMPLETED	
		245490	B. WING			05/1	5/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
OAK HIL	LS LIVING CENTER				314 EIGHTH STREET NORTH IEW ULM, MN 56073		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 157	the resident from the §483.12(a). The facility must als and, if known, the re- or interested family change in room or re- specified in §483.1 resident rights under regulations as spect this section. The facility must react the address and philegal representative This REQUIREMEN by: Based on observate review the facility fa- interested family more resident (R94) who an incident. Findings include: During interview on complained of pain she said she had re- ran the wheelchair of diagnoses including degenerative joint of pain and takes sche and oxycodone. The	ge 1 cision to transfer or discharge the facility as specified in so promptly notify the resident esident's legal representative member when there is a roommate assignment as 5(e)(2); or a change in er Federal or State law or cified in paragraph (b)(1) of cord and periodically update one number of the resident's e or interested family member. NT is not met as evidenced tion, interview and document isled to notify the physician and ember of injury for 1 of 1 had pain in the right toe after 5/13/14 at 9:54 a.m., R94 in her right foot from a bruise eceived when staff accidentally over her right foot. R94 had g osteoarthrosis (arthritis), lisease (DJD) and generalized eduled extra strength Tylenol e minimum data set (MDS) ated that R94 was cognitively	F1	57	CORRECTIVE ACTION- AFFECTE RESIDENT: Resident R94 was note having her toe run over by a w/c by s while she was sitting on the side of h bed during the night before 5/6/14. J initial bruise monitoring flow sheet w started on this incident and the Day made a progress note. However, th staff member failed to complete a fa specific risk management report, no the physician or family member of th incident, nor was the pain concern b resident passed along to appropriate personnel. On 5/14/14 a proper inci report was eventually placed into fac risk management program and prim care provider was notified of the situ The resident was also seen by Clinic Nurse Practitioner on 5/15/14 and th	ed as staff ner An vas nurse ne ucility otify ne by the e ident cility ary lation. cal	

Facility ID: 00041

If continuation sheet Page 2 of 19

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245490 **B** WING 05/15/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1314 EIGHTH STREET NORTH** OAK HILLS LIVING CENTER **NEW ULM, MN 56073** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 157 Continued From page 2 F 157 During an observation on 5/14/14, at 2:00 p.m. resident declined any radiographs. licensed practical nurse (LPN)-A removed R94's Resident was offered icing of foot four sock of the right foot. The right great toe and next times a day as needed, but indicated she two toes were bluish green in color and painful was not interested in this therapy and thought she was doing better and that the when LPN-A touched the great toe. toe did not hurt unless it was manipulated. During an interview on 5/14/14, at 1:15 p.m. Bruising charting continued until the LPN-A indicated she was unsure when the bruise subsided. incident occurred. LPN-A stated, "She told the The Nurse who originally noted the bruise day girls it happened at night but she did not was educated about the policy and the report it to me till after lunch". LPN-A confirmed it policy was reviewed to ensure from now was not reported to the primary care provider on that all documentation including an (PCP) and was unable to verify whether the incident report must be done on any family had been notified, stating "can't recall if I accidents or incidents involving Residents. did ". Further education regarding the proper way to handle resident incidents and The progress notes dated 5/6/14 and authored by accidents will be discussed at an LPN-A, indicated R94 complained of the right foot upcoming staff meeting of licensed 'hurting'. Documentation indicated R94 informed nurses. During that meeting, there will LPN-A "her foot was run over by her w/c also be discussion about appropriate (wheelchair) when she was sitting on the edge of follow up with pain control and her bed". Documentation indicated discomfort documentation requirements as outlined was noted when the toes was palpated (touched) in existing OHLC policy. but had no increased pain with movement of the toe. ACTUAL/PROPOSED COMPLETION DATE: June 04, 2014 During an interview on 5/14/14, at 1:45 p.m. the director of nursing (DON) verified he would have PERSON(s) RESPONSIBLE FOR expected that the physician would have been CORRECTION/MONITORING: notified. Immediate corrective monitoring and oversight of the resident s care on 5/14 The document, Procedure for Incident (Resident) and 5/15/14 was done by DON. The DON Documentation, indicated the supervisor or staff and Staff Development Nurse will be nurse who observed, discovered or directly doing the educational offering on incident involved in the incident complete a report and the and accident reporting and appropriate medical doctor (MD) and family will be notified. 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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 06/09/2014

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/09/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245490	B. WING _		05/15/2014		
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
OAK HIL	LS LIVING CENTER			-	14 EIGHTH STREET NORTH EW ULM, MN 56073		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	Continued From pa	ge 3	F 157				
F 241 SS=D	483.15(a) DIGNITY INDIVIDUALITY	AND RESPECT OF	F 24	41	practice management.		6/18/14
	manner and in an e enhances each resi	omote care for residents in a nvironment that maintains or ident's dignity and respect in s or her individuality.					
	by: Based on observat review the facility fa (R111) in a dignified experience. Findings include: While observing the 5/12/14, at 5:30 p.m gait belt around her meal. During a second ob experience on 5/14, that R111 had a gai throughout the noor During an interview R111 verbalized she belt throughout the asked if it bothered she stated "I don't li R111's quarterly Min 3/28/14 indicated m	on 5/14/14, at 2:00 p.m., e did not like wearing the gait meals. When R111 was her emotionally or physically,			CORRECTIVE ACTION- AFFECTE RESIDENT: On 5/12 and 5/14/14 it noted that Resident R111 did not ha Gait Belt removed once reaching he at the dining room table. As per fac policy, it states that the gait belt will removed once resident is sitting. St failed to remove the gait belt and als failed to ask the resident if it was ok leave the gait belt on. On 5/16/14 N Case manager discussed with Resi the reason why the staff member ha the gait belt on was to avoid injury w the Resident attempts to ambulate a from the table quickly. Resident wa agreeable to wearing the gait belt at meals from the 16th on as the Resid felt that this was the safest practice. Resident s care plan was updated to re the importance of gaining the permi of the Resident to keep on the gait k Residents who may be at risk of fall when getting up quickly. This new p will be presented at the 6/4/14 and	was ave her er seat cility be taff so cay to Nurse dent ad kept vhen away is t dent to flect ssion belt for ing	

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If continuation sheet Page 4 of 19

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245490 B. WING 05/15/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1314 EIGHTH STREET NORTH** OAK HILLS LIVING CENTER **NEW ULM, MN 56073** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 241 Continued From page 4 F 241 R111 is at risk for falls related to gait and balance 6/18/14 staff meetings. problem. One of the interventions included indicated the use of adaptive appliances which ACTUAL/PROPOSED COMPLETION included a gait belt and to ensure the least DATE: 6/18/14 restrictive device or appliance used. There was no planned intervention that a gait belt was PERSON(s) RESPONSIBLE FOR required throughout meal times. CORRECTION/MONITORING: DON and Staff Development updated policy. DON and Staff development will present gait During an interview with the director of nursing (DON) on 5/15/14, at 9:30 a.m. it was indicated belt policy changes at the 6/4/14 and that he expected staff to remove the gait belt 6/18/14 meetings. 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 309 483.25 PROVIDE CARE/SERVICES FOR F 309 6/18/14 HIGHEST WELL BEING SS=D 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 bv: Based on observation, interview and document CORRECTIVE ACTION- AFFECTED review the facility failed to monitor and manage **RESIDENT: Resident R94 was noted to** pain for 1 of 3 residents (R94) reviewed who have the injury 5/6/14 in which a w/c ran experienced pain. over Resident's foot. Resident is on scheduled pain medication as indicated in

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 06/09/2014

CENTER STATEMENT	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	ON				06/09/2014 APPROVED 0938-0391
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _		COM	PLETED
		245490	B. WING _		05/15/2014		
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
OAK HILL	S LIVING CENTER			-	14 EIGHTH STREET NORTH EW ULM, MN 56073		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	complained of pain she said she had re ran the wheelchair of "I 'm suffering with During interview on R94 she stated, "the wheelchair. It hurts toes then it is OK ". type of pain. During 12:45, it was noted wheelchair in the ha to the right and bur medication cart. R94 had diagnoses (arthritis), degeneral generalized pain an strength Tylenol and data set (MDS) date was cognitively inta- During an observati licensed practical m sock of the right foo two toes were bluisl when LPN-A touche During an interview LPN-A indicated she incident occurred. I day girls it happene report it to me till aff was not reported to (PCP) and was una	5/13/14 at 9:54 a.m., R94 in her right foot from a bruise eceived when staff accidentally over her right foot. R94 stated, that, it hurts". 5/14/14, at 12:45 p.m. with ey drove over it with the to step on it. If I don't lift my R94 denied having any other g an observation on 5/14/14 at that R94 propelled the allway with her left foot, veered hped into the wall and including osteoarthrosis tive joint disease (DJD) and d takes scheduled extra d oxycodone. The minimum ed 2/14/14 indicated that R94 ct. on on 5/14/14, at 2:00 p.m. urse (LPN)-A removed R94's ot. The right great toe and next h green in color and painful	F 3(09	observation. Resident was seen by Practitioner on 5/15/14 in which res refused Ice pack application and als refused any X-Ray of the foot. Comprehensive pain flowsheet was initiated on 5/15/14 for every week of Thursdays, day shift. Code of 12 indicated on TAR, indicating no pair issues noted. Pain interview condu on 5/16/14 (coinciding with ARD of 1 R94 answered yes to having pain, describing it as mild. Resident will a again 6/5/14. Staff did fail to inform provider on initial injury notation. Discussion and education of approp incident/accident response as well a documentation will be discussed at and 6/18/14 staff meetings. In futur situations, staff will ensure that phys is called. As a side note, a current Quality Init is underway involving much of the interdisciplinary team at OHLC to fit better ways to document and contro This project will continue through th calendar year and will be instrumen incidents like this. In the interim, be communication and follow up with p be discussed at the 6/4 and 6/18/14 meetings. ACTUAL/PROPOSED COMPLETIO DATE: 6/18/14 PERSON(s) RESPONSIBLE FOR CORRECTION/MONITORING: Cas Managers, Charge Nurses, and DO be responsible to ensure appropriat documentation and follow up with in	ident so ident so ident so in cted MDS). also f/u briate as 6/4/14 re sician tiative hd bl pain. e tal in etter bain will staff DN	

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		IG	· · ·	PLETED	
		245490	B. WING _		05/	15/2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
OAK HIL	LS LIVING CENTER			1314 EIGHTH STREET NORTH NEW ULM, MN 56073			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE	
F 309		Continued From page 6		99			
	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.			and accidents, including appropriate Risk Management documentation and contacting of providers as well as follow up for any pain issues from the accident.			
	director of nursing expected that the p notified and that int	on 5/14/14, at 1:45 p.m. the (DON) verified he would have obysician would have been erventions, which included hould have been implemented.					
	reported she saw th declined an x-ray a indicated a follow-u scheduled for next	on 5/15/14, at 12:00 p.m. R94 he nurse practitioner (NP) and t the hospital. R94 further up visit with the NP was week. R94 further confirmed continues when attempts to					
	Documentation, dir staff nurse observir involved in the incid report thoroughly a	becedure for Incident (Resident) ects that the supervisor or ng, discovering or directly dent will complete the incident nd completely and then he Case Manager, DON and					

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		AND HUMAN SERVICES			FORM	06/09/201 APPROVE 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	E SURVEY
		245490	B. WING _		05/	15/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
OAK HIL	LS LIVING CENTER			1314 EIGHTH STREET NORTH NEW ULM, MN 56073		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 309	Continued From pa	ae 7	F 30	99		
	•	(MD) and family will be				
F 318 SS=D	483.25(e)(2) INCRI IN RANGE OF MO	EASE/PREVENT DECREASE TION	F 3′	18		6/18/14
	resident, the facility with a limited range appropriate treatme	orehensive assessment of a r must ensure that a resident e of motion receives ent and services to increase d/or to prevent further of motion.				
	by: Based on observative review the facility fatistic fat	NT is not met as evidenced tion, interview and document ailed to provide ongoing further decrease in range of e lower extremities for 1 of 2 riewed who had limited range		CORRECTIVE ACTION- AF RESIDENT: As indicated in Resident R82 was going thre contractures of lower extrem knee brace was started on the May 2013 for the left knee.	observations, ough PT for neties where a he Resident in The use of	
	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;			the brace caused abrasions of the area almost immediat of this, PT had requested the discontinued on 5/29/13 and practitioner be notified of the reaction to the brace or mate associated with the brace. T documentation indicated tha healing of the abrasions to h Nurse Practitioner reevaluat for further intervention. On 6 noted that the abrasions had however, staff failed to reque assessment for the brace fro practitioner. On 5/22/14, staff requested	ely. Because e brace be l nurse e adverse erials The t once the ave the e the resident 6/17/13, it was d cleared, est another om the Nurse	

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PRINTED: 06/09/2014 FORM APPROVED

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CON	1PLETED	
		245490	B. WING _		05/	15/2014	
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CC	DE		
OAK HIL	LS LIVING CENTER			1314 EIGHTH STREET NORTH NEW ULM, MN 56073			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 318	potential to develop assessment indicat should be consider placed on a regular bed and chair. Review of the phys revealed R82 recei 5/1/13. The PT pla indicated R82 had both lower extremit extension, with the tone and tightness. at risk for contractu further indicated: "F is lacking 25 degre knee is lacking 70 d [sic]but with prolom break tone to 60 de Further review of P revealed a need fo R82's left knee "as pt (patient) due to F tone." A DynaPro F purchased for R82 The PT discharge s indicated R82's cur "Patient able to ext knee extension bra as noted: (1) PT v techniques to be in contractures of the improve transfers v	a higher the score, the greater o contractures. This ted that scores higher than 7 ed at risk and should be r positioning schedule for both ical therapy (PT) notes wed PT services from 4/12/13 - in of care dated 4/12/13 increased muscle tightness in ties (LE's) affecting knee left side affected by increased . Due to the tightness R82 was tres. The PT plan of care ROM: R (right) knee extension es of extension and the L (left) degrees of extension initiaially ged light stretch was able to egrees lacking." T notes dated 4/16/13 r a prolonged stretch brace for manual stretch will not benefit her severe contractures and knee extension brace was summary dated 5/1/13 rrent level of function as: end knee to 50 degrees with ice." The long term goals were will train the staff in stretching plemented daily to prevent bilat (bilateral) knees and with the EZ stand and nonstrate bilateral knee	F 31	 8 evaluation for Resident R82 Extremities and Lower Extremicontractures. It is noted that that previous requests for Baddenied by Resident is family the family member did not feen help resident be more relaxed (muscularly). PT felt like resident is family the family member did not feen help resident. Resident is family muscle tone and allow better for Resident. Resident is family the family member to the start of Resident. Resident is family was started with the start of again with sheep skin covering Resident is currently in PT at On 6/4 and 6/18/14 staff mean importance of documentation discussed. A discussion with the started with the start is happening every Wedneso Medicare meetings. ACTUAL/PROPOSED COMIDATE: 6/18/14 PERSON(s) RESPONSIBLE CORRECTION/MONITORIN Neighborhood 1 Case Manag Charge nurse and Aegis The monitor Resident care and for the started reasons. 	mities PT reports aclofen were member as el this would d ident could decrease stretching mily member ent on d resident in. The left b be used ng. The t this time. etings, the n will be n Aegis nication m members day during PLETION FOR IG: ger, DON, rapies will		

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		AND HUMAN SERVICES				FORM	06/09/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245490	B. WING	;		05/	15/2014
NAME OF F	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
OAK HIL	LS LIVING CENTER				1314 EIGHTH STREET NORTH NEW ULM, MN 56073		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 318	indicated: "Patient H extended periods of Therefore, the need and nursing can no of the brace. Nursi proper donning and Review of the nursi 5/29/13 at 1:45 p.m have quarter sized reddened. Will inia area." The nursing at 2:41 p.m. indicate (occupational thera and abrasions. OT and have NP (nurse once abrasions hea heal for new orders nursing progress no "Dc'd monitoring for scab is off of knees limits)." R82's reco no follow-up with th healed was found. During interview on spouse/family mem been performing pat (PROM) to R82's up she was discharged FM-D confirmed the him with PROM train never been trained FM-D stated he was providing that service During interview on	he discharge summary further has tolerated the brace for f time in supine, sidelying. d for physical therapy is limited w take over for the placement ng staff has been trained in d doffing of knee brace." ng progress notes dated h. revealed: "Patient noted to abrasion on left knee. Area is te [sic] flowsheet to monitor progress note dated 5/29/14 ed: "Writer spoke with PT/OT py) regarding residents brace i stated to put brace on hold e practitioner) give new order aled. Will await abrasion to h. Further review of the otes dated 6/17/13 indicated: r skin redness, Resolved. skin WNL (within normal ord was reviewed further and e NP once the abrasion was 15/14/14 at 11:24 a.m., R82's aber (FM)-D stated he had assive range of motion pper extremities (UE's) since d from therapy [6/17/13]. e OT department had provided ining for R82's UE's but had to do PROM to her LE's. s unsure if therapy was ce. 5/14/14, at 1:15 p.m., nursing	F	318	3		
		ated that PROM to the lower					

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		AND HUMAN SERVICES				FORM	06/09/2014 APPROVED 0938-0391
STATEMENT OF DEFICI AND PLAN OF CORREC	ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245490	B. WING			05/ ⁻	15/2014
NAME OF PROVIDER (OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
OAK HILLS LIVING	G CENTER				314 EIGHTH STREET NORTH IEW ULM, MN 56073		
PREFIX (EAC	CH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
extremit approxim PROM f assignm therapy During i stated th it wasn't was "so during d that rout expecta During i practica to utilize after a s LPN-B w recomm subsequ brace. During i director further r from phy electron after dis evaluatii F 329 SS=D	mately 2-3 r for R82 was nent sheets for at least interview on hat R82 pre- t worn very tight". NA-/ dressing but tine PROM tion. Interview on a knee bra- skin issue of was unsure nendations b uent to the of notes and/o ysical thera nic record of scontinuatio ons and/or I) DRUG RE ESSARY D sident's dru ssary drugs nen used in re therapy);	 been performed with R82 for months. NA-B confirmed that is no longer on the NA's and that R82 had not been in that long. 5/15/14, at 1:02 p.m., NA-A eviously wore a knee brace but long due to the fact her knee A stated PROM is attempted is difficult. NA-A confirmed for R82 had not been the 5/15/14 at 1:21 p.m., licensed N)-B confirmed that R82 used ace which was discontinued ccurred from the brace. whether any further by therapy had occurred discontinuation of the knee 5/15/14 at 2:11 p.m., the confirmed there were no r recommendations evident py after 5/1/13 in the f R82. The DON verified that n of the knee brace no further follow-up had occurred. EGIMEN IS FREE FROM 		318			6/18/14

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	FORM A	06/09/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245490	B. WING	B. WING			5/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
OAK HIL	LS LIVING CENTER		1314 EIGHTH STREET NORTH NEW ULM, MN 56073				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and o record; and residen drugs receive gradu behavioral intervent	se; or in the presence of nees which indicate the dose or discontinued; or any	F 3	29			
	by: Based on observat interview the facility side effects of a blo 5 residents (R103) medications. Findings include: R103 had diagnose and congestive hea the physician orders Coumadin (an antio the blood and incre (milligrams) po (by and Tuesday, and C	NT is not met as evidenced ion, document review and failed to monitor the potential od thinning medication for 1 of reviewed for unnecessary es including atrial fibrillation int failure (CHF). Review of s revealed R103 received coagulant medication that thins ases risk of bruising) 5 mg mouth) daily every Sunday Coumadin 7.5 mg po daily dnesday, Friday, and			CORRECTIVE ACTION- AFFECTED RESIDENT: As indicated in above observation, Resident R 103 care plat had indicated that bruising would be monitored. Facility policy states that a unusual bruising must be annotated in progress notes and a bruise flowshee be started for bruises larger than 3cm 3cm. Investigation indicates that Nurs Assistant states that she reported the bruising on about 5/13/14, but does no remember to which nurse this was reported. An incident reports was plat into Risk Management and bruise monitoring was started subsequently 5/15/14. Although Resident R103 felt	an any in et will n by rsing e not aced on	

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245490 **B** WING 05/15/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1314 EIGHTH STREET NORTH** OAK HILLS LIVING CENTER **NEW ULM, MN 56073** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 329 Continued From page 12 F 329 Saturday. The plan of care (undated) included: the bruises were related to several IV "Monitor/document/report any redness, open sticks at the ER, it is still policy that such areas, scratches, cuts bruises to charge nurse", bruising be reported to the immediate and "Monitor/document/report to MD (medical supervisor. The Resident denied any pain doctor) PRN (as needed) s/sx (signs/symptoms) with the bruising and the bruising has of complications..." that included bruising. subsided since this incident. Staff will be educated about Communication of resident findings as During observation/interview on 5/12/14 at 6:58 p.m., R103 was observed with a large bruise on well as incident and accident reporting the anterior of the left forearm, a nickel size and documentation during the 6/4 and bruise on the anterior aspect of the right wrist, 6/18/14 staff meetings. Staff will have and bruising in the antecubital space of the right policy refreshment during this instruction. and left arm which R103 attributed to a blood draw. ACTUAL/PROPOSED COMPLETION DATE: 6/18/14 During interview on 5/15/14 at 9:43 a.m., licensed practical nurse (LPN)-A stated upon discovery of PERSON(s) RESPONSIBLE FOR a noted bruise, it is measured and investigated CORRECTION/MONITORING: DON, for the cause and if the bruise is larger than 3 Staff Development, and Case Managers inches or if unable to identify the cause, an will be responsible for upholding company incident report is completed. Subsequently, staff policy and procedure. Individual and monitor the bruise and document on the group educational offerings will happen treatment administration record (TAR) until 6/4 and 6/18/14 and as needed for any resolved. LPN-A confirmed there were no bruises subsequent violation or concern. 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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES				FORM	06/09/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245490	B. WING			05/ [,]	15/2014
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
OAK HIL	LS LIVING CENTER				314 EIGHTH STREET NORTH IEW ULM, MN 56073		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329 F 371 SS=F	assisted R103 with identified the bruisir indicated she had re ago", although could had been reported. had indicated it was Review of R103's in 10:30 a.m. included space It. (left) arm of measures 1x1 cm (arm dark grey bruis (left) medial forearm reddish color. Rt. a further documentati was available for re 483.35(i) FOOD PR STORE/PREPARE/ The facility must - (1) Procure food fro considered satisfac authorities; and (2) Store, prepare, of under sanitary cond	morning cares and had ng to R103's arms. She eported this to a nurse "2 days dn't remember which nurse it NA-A further stated that R103 s from a blood draw. Incident report dated 5/15/14 at d: "Noted bruise antecubital color fading It (light) green centimeter). Anterior Lt. lower se measures 6.8 x 4 cm. Lt in bruise measures 1 x 6 cm arm measures 2 x 1.2 cm." No ion related to the bruised area eview. ROCURE, /SERVE - SANITARY	F 3				5/21/14
	by: Based on observat review the facility fa environment in the	tion, interview and document ailed to maintain a sanitary dietary area which had the 8 of 88 residents who were			CORRECTIVE ACTION- AFFECTI RESIDENT: As indicated in observa several areas of concern were note about the cleanliness of certain are within the kitchen; both F tags 465 a 371 are similar regarding the nature	ation, d as and	

Event ID: SE3E11

Facility ID: 00041

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TATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURV COMPLETE		
		015100					
		245490	B. WING _			15/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1314 EIGHTH STREET NORTH NEW ULM, MN 56073	Ε		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	IOULD BE	(X5) COMPLETIO DATE	
F 371	5/12/14 at 3:45 p.m were made: (1) The Hobart over food preparation ar heavy build-up of d gas knobs used to observed to be hear grease with balls of control panel. Furth the stove and food heavily soiled with f (2.) An Echo water to the wall by the di filter had a heavy ar appearance, with cr to portion of the bu (3.) The primary co observed to have e cooler fan casing a area was noted to h be visualized upon cooling fan was blo items stored in the (4.) The large stand preparation area wa have food debris or agitator motor, and the mixer was cove and the DM stated stated the mixer sh each use.	ar of the dietary area on the following observations an and stove in the kitchen ea was observed to have a ust on their top surfaces. The regulate fire temperature was ivily soiled with dust and dust noted under the lip of the her, the wheels and frame of warmer were noted to be food debris, dust and grease. filter was observed mounted shwashing loading area. The ccumulation of dust, fuzzy in obwebs noted on the back and racket and filter. oler used for food storage was xcess dust build-up on the nd coolant feed lines. The have heavy dust which could entering the cooler. The wing across multiple food cooler. d mixer in the kitchen food as inspected and noted to n the mixer agitator arm, frame. When first observed ared with a plastic garbage bag the mixer was clean. The DM ould have been cleaned after th the DM on 5/12/14, at 4:10	F 37	 ⁷¹ cause of such deficiencies. The deficiencies are central to lact up and follow through with clear and ensuring a QA and audit previses to make sure cleaning has regular basis. On 5/21/14 a dietary staff meet held with Dietary Manager and Manager in which the cleaning revised to focus on all areas of as well as any other cleaning in to help prevent the spread of fillness. The Kitchen Manager will be comonthly audits of all cleaning I as spot audits throughout the which will include inspection or deficiency and all other food s areas. This will ensure the ad cleanliness of all food service Education and/or disciplinary at taken (promptly) for any staff who fail to provide a safe food area. ACTUAL/PROPOSED COMPLICATE: 5/21/14 PERSON(s) RESPONSIBLE FORRECTION/MONITORING Manager and Kitchen Manager of service areas as well as QA Are Educational Offerings will be material staff regarding the requirement cleaning within the food service 	k of follow aning lists orogram appens on a eting was d Kitchen g lists were f deficiency requirement ood borne loing ists as well month f areas of ervice equate areas. action will be who have ing tasks or service LETION FOR S: Dietary rr will be food udits. nade for all its of		

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 06/09/2014 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
		245490	B. WING		05/15/2014		
NAME OF F	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
OAK HILI	LS LIVING CENTER			314 EIGHTH STREET NORTH NEW ULM, MN 56073			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 371 F 465 SS=C	always been complestated there had be stated there had be staffing consistency During observation kitchen environmen following findings w (1.) The top surface continued to have a on them. It was evid been wiped since in and rear surface wa heavily soiled and (2 had brown residue a assembly between At 5/14/14 at 1:00 p of the April and May cleaning schedule h projects that were n The DM stated, bas kitchen, she believe performed as sched On 05/14/14 at 2:12 DM she verified the concern for her and confidence that the with the cleaning sci identified areas of c satisfactorily to prov storing, serving and 483.70(h) SAFE/FUNCTIONA E ENVIRON	kitchen and realized it had not eted as scheduled. The DM een some problems with /. of the food preparation and at on 5/14/14 at 11:15 a.m. the ere again observed: es of the oven and stove a coating of dust and grease dent the stove and oven had hitial observation but the center as missed and continued to be 2.) The large stand mixer still around base of motor the motor and agitator arm. o.m. the DM submitted a copy / 2014 cleaning schedule. The had multiple areas of cleaning not signed off as completed. sed on the findings in the ed the cleaning was not being duled. 2 p.m. during interview with dietary cleaning was a 3 she verbalized lack of evening shift had complied chedules. The DM verified the concern had not been cleaned vide a sanitary environment for	F 371			5/21/14	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER OAK HILLS LIVING CENTER				PRINTED: 06/09/20' FORM APPROVE OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED B. WING 05/15/2014 STREET ADDRESS, CITY, STATE, ZIP CODE 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)			IX i	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	۷		
F 465	sanitary, and comfor residents, staff and This REQUIREMEN by: Based on observat failed to maintain a environment in the floors, walls and eq potential to affect 8 Findings include: During the initial tou 5/12/14 at 3:45 p.m were made: (1.) The floor drain room near the dish a build-up of brown surrounding floor til on the floor tiles wa matter. This was loo the dirty dishes wer The dietary manage been problems with and the floor had be cleaning had been approximately a mo- heavy buildup of wh and along the wall e the dishwasher are the soiled area whe processed to the ar dishwashing area w	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 botential 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 foom 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 neavy buildup of white substance on floor tiles and along the wall extending the entire length of the dishwasher area. This area extended from the solled area where the dirty dishes were processed to the area on the clean side of the dishwashing area where clean dishes were mandled. Underneath the clean side of the		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 t 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 or 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 deficient as well as any other cleaning requirement to help prevent the spread of food borner illness. The Kitchen Manager will be doing monthly audits of all cleaning lists as we 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 taken (promptly) for any staff who have not completed assigned cleaning tasks who fail to provide a safe food service area. ACTUAL/PROPOSED COMPLETION	the v s n a e cy ent e e ll s			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/09/2014 APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
		245490	B. WING			05/15/2014				
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE					
OAK HIL	LS LIVING CENTER			1314 EIGHTH STREET NORTH NEW ULM, MN 56073						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 465	LS LIVING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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		F 4	465	DATE: 5/21/14 PERSON(s) RESPONSIBLE FOR CORRECTION/MONITORING: Die Manager and Kitchen Manager will conducting thorough audits of food service areas as well as QA Audits. Educational Offerings will be made staff regarding the requirements of cleaning within the food service are	be for all				

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	06/09/2014 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245490	B. WING		05/ [.]	05/15/2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
OAK HIL	LS LIVING CENTER			314 EIGHTH STREET NORTH NEW ULM, MN 56073			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 465	 (2.) The fire alarm s dry storage room d heavy coating of du (3.) Two breaker box kitchen in food prep have heavy build-up top and rear portion At 5/14/14 at 1:00 p of the April and May cleaning schedule if projects that were r The DM stated, bas kitchen, she believe performed as schere On 05/14/14 at 2:12 DM she verified the concern for her and confidence that the with the cleaning so identified areas of control 	 strobe light on the wall by the loor remained soiled with a ust and grime; and oxes located on the wall in the paration area were noted to p of dust and cobwebs on the ns of both of both. o.m. the DM submitted a copy y 2014 cleaning schedule. The had multiple areas of cleaning not signed off as completed. sed on the findings in the ed the cleaning was not being duled. 2 p.m. during interview with e dietary cleaning was a d she verbalized lack of e evening shift had complied chedules. The DM verified the concern had not been cleaned vide a sanitary environment for 	F 465				

Facility ID: 00041

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				8	F5490022		APPROVED . 0938-0391
			(Y2) MU		CONSTRUCTION		E SURVEY
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				1 - MAIN BUILDING 01		PLETED	
		245490	B. WING			05/	/21/2014
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
OAK HIL	LS LIVING CENTER				W ULM, MN 56073		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	кc	000			
	FIRE SAFETY						
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST MS-2567 WILL BE USED AS COMPLIANCE.					
	ON-SITE REVISIT CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION.					
	Minnesota Departm Fire Marshal Divisio time of this survey, Center was found n with the requiremen Medicare/Medicaid 483.70(a), Life Safe edition of National F	Survey was conducted by the nent of Public Safety, State on, on May 21, 2014. At the Building 01 of Oak Hills Living not in substantial compliance hts for participation in at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association fety Code, Chapter 19 e Occupancies.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K- Health Care Fire In State Fire Marshal 445 Minnesota Stree	R THE FIRE SAFETY TAGS) TO: spections Division			EPOC		

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

St. Paul, MN 55101-5145, or

TITLE

06/06/2014

(X6) DATE

PRINTED: 06/23/2014

Electronically Signed

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.

	RINTED: 06/23/2014 FORM APPROVED MB NO. 0938-0391							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED	
		245490	B. WING			05/21/2014		
NAME OF F	PROVIDER OR SUPPLIER							
OAK HIL	LS LIVING CENTER				814 EIGHTH STREET NORTH EW ULM, MN 56073			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 000	By E-Mail to: Marian.Whitney@st THE PLAN OF COF DEFICIENCY MUS FOLLOWING INFO 1. A description of w to correct the deficie 2. The actual, or pro 3. The name and/or responsible for corre prevent a reoccurre Building 01 of Oak I constructed in 1995 basement, is fully fin determined to be of nursing home is sep facility by a two-hou protective consisting positive latching, 90 assembly. The facility has a fin detection in the corr corridors which is m department notifical protected with autor interconnected smoothed	atte.mn.us RRECTION FOR EACH TINCLUDE ALL OF THE RMATION: what has been, or will be, done ency. oposed, completion date. title of the person ection and monitoring to nce of the deficiency. Hills Living Center was , is two-stories, has no re sprinkler protected and was Type II(111) construction. The parated from an assisted living r fire wall with an opening g of a labeled, self-closing, -minute fire-rated door	KO	00				
K 011	time of the survey. The requirement at NOT MET as evider	42 CFR, Subpart 483.70(a) is	K 0	11			7/18/14	

Event ID: SE3E21

Facility ID: 00041

If continuation sheet Page 2 of 4

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM /	06/23/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMF	SURVEY PLETED
		245490	B. WING			05/2	1/2014
NAME OF F	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
OAK HILI	LS LIVING CENTER				814 EIGHTH STREET NORTH EW ULM, MN 56073		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 011 SS=F	nonconforming built barrier having at lear rating constructed of addition. Communi- corridors and are pr	ge 2 ding, the common wall is a fire ast a two-hour fire resistance of materials as required for the icating openings occur only in rotected by approved irs. 19.1.1.4.1, 19.1.1.4.2	K	011			
	Based on observations of the second ance with NF Code" 2000 edition deficient practice consultation to trave which could negative fire emergency. Findings include: During the facility to AM and 3:00 PM or that the 1st floor 2-1 the Nursing Home a building had been of barrier wall and not	s not met as evidenced by: tions and interview it was 2-hour fire barriers are not in PA 101 "The Life Safety (LSC) section 19.1.1.4.1. This build allow the products of al from one building to another, rely impact all 87 residents in a bur between the hours of 11:30 n 5/21/2014, it was observed hour fire barrier wall between and the Independent Living constructed for a 1-hour fire a 2-hour fire barrier wall not in SC (00) edition section			K11- UPDATED CORRECTIVE AC We are working with a contractor to wall separating the nursing home al HUD Building in Assisted Living to a hour separation wall. This will be completed when we do the remode current assisted living. Completion will be July 18, 2014. Environmenta Services Supervisor will monitor.	fix the nd 2 2 I of our date	
K 050	finding of the deficient inspection.	Maintenance verified this ent practice at the time of the FETY CODE STANDARD	K	050			7/5/14

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

Facility ID: 00041

If continuation sheet Page 3 of 4

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/23/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMI	SURVEY PLETED
		245490	B. WING		h	05/2	21/2014
NAME OF F	PROVIDER OR SUPPLIER	£			TREET ADDRESS, CITY, STATE, ZIP CODE 314 EIGHTH STREET NORTH		
OAK HIL	LS LIVING CENTER				EW ULM, MN 56073		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG K 050 SS=F	Continued From par Fire drills are held a varying conditions, The staff is familiar that drills are part o Responsibility for pl assigned only to co qualified to exercise conducted between announcement may alarms. 19.7.1.2 This STANDARD is Based on review o interview, it was det to vary the times for drills for each shift i accordance with NF 19.7.1.2. This defici staff react in the eve by staff would affec Findings include: On facility tour betw on 5/21/2014 a revir reports in 2013-201 conducted Day-shift of 10:23 AM, 9:21 A Night-shift drills bet AM, 1:00 AM not at Section 19.7.1.2.	ge 3 at unexpected times under at least quarterly on each shift. with procedures and is aware f established routine. lanning and conducting drills is mpetent persons who are e leadership. Where drills are a 9 PM and 6 AM a coded y be used instead of audible s not met as evidenced by: f reports, records and termined that the facility failed r the required number of fire in the last 12-month period in -PA 101 LSC (00) Section ient practice could affect how ent of a fire. Improper reaction t the safety of all 87 patients. veen 11:00 AM and 3:00 PM ew of the available fire drill 4 revealed that the facility t fire drills between the hours AM, 10:12 AM, 9:07 AM, ween 2:00 AM, 3:00 AM, 2:00 c varied times as required by		050		ed and etion o later sible for	
	a maintenan						

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

Facility ID: 00041

If continuation sheet Page 4 of 4

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		& MEDICAID SERVICES	/			0. 0938-0391 TE SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG 02 - BLDG 2		MPLETED
		245490	B. WING		05	/21/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1314 EIGHTH STREET NORTH	E	
OAK HIL	LS LIVING CENTER			NEW ULM, MN 56073		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	K 00	10		
	FIRE SAFETY			5		
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST MS-2567 WILL BE USED AS COMPLIANCE.				
	ON-SITE REVISIT CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departm Fire Marshal Divisio time of this survey, Center was found n with the requiremen Medicare/Medicaid 483.70(a), Life Safe edition of National F	Survey was conducted by the nent of Public Safety, State on, on May 21, 2014. At the Building 02 of Oak Hills Living not in substantial compliance hts for participation in at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association fety Code, Chapter 18 New ancies.				
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K- Health Care Fire Ins State Fire Marshal 445 Minnesota Stre	R THE FIRE SAFETY TAGS) TO: spections Division		EPOC		
	St. Paul, MN 55101					

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.

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		0. 0938-039 TE SURVEY
	OF DETICIENCIES	IDENTIFICATION NUMBER:		NG 02 - BLDG 2		MPLETED
		245490	B. WING		05	5/21/2014
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1314 EIGHTH STREET NORTH		
OAK HIL	LS LIVING CENTER			NEW ULM, MN 56073		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	Continued From pa By E-Mail to: Marian.Whitney@s		K 0(DO		
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:				
	1. A description of v to correct the defici	vhat has been, or will be, done ency.				
	2. The actual, or pro	oposed, completion date.				
		r title of the person ection and monitoring to ence of the deficiency.				
	constructed in 2009 basement, is fully fi	Hills Living Center was), is two-stories, has no re sprinkler protected and was [•] Type II(111) construction.				
	detection in the corr corridors which is n department notifica protected with auto interconnected smo nurse call system.	re alarm system with smoke ridors and spaces open to the nonitored for automatic fire tion. All resident rooms are matic, hard wired, oke detectors connected to a The facility has a capacity of census of 87 at time of the				
K 050 SS=F	NOT MET as evide NFPA 101 LIFE SA	FETY CODE STANDARD	K 0	50		7/5/14
	varying conditions,	at unexpected times under at least quarterly on each shift. with procedures and is aware				

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

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/23/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 02 - BLDG 2		E SURVEY PLETED
		245490	B. WING			05/2	21/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
OAK HIL	LS LIVING CENTER				314 EIGHTH STREET NORTH EW ULM, MN 56073		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 050	Responsibility for pl assigned only to co qualified to exercise conducted between announcement may alarms. 18.7.1.2 This STANDARD is Based on review o interview, it was det to vary the times fo drills for each shift i accordance with NF 19.7.1.2. This defic staff react in the ev- by staff would affec Findings include: On facility tour betw on 5/21/2014 a revi reports in 2013-201 conducted Day-shif of 10:23 AM, 9:21 A Night-shift drills bet AM, 1:00 AM not at Section 19.7.1.2.	f established routine. lanning and conducting drills is mpetent persons who are e leadership. Where drills are 9 PM and 6 AM a coded y be used instead of audible s not met as evidenced by: f reports, records and termined that the facility failed r the required number of fire n the last 12-month period in FPA 101 LSC (00) Section ient practice could affect how ent of a fire. Improper reaction t the safety of all 87 patients. veen 11:00 AM and 3:00 PM ew of the available fire drill 4 revealed that the facility t fire drills between the hours M, 10:12 AM, 9:07 AM, ween 2:00 AM, 3:00 AM, 2:00 varied times as required by the	K	050	K 50- UPDATED CORRECTIVE ACTION- Fire drills will be schedule varied throughout all shifts. Compl date was moved back and will be r than July 5, 2014. Environmental Services Supervisor will be respon monitoring and correction of this pl	etion io later sible for	

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

Facility ID: 00041

If continuation sheet Page 3 of 3



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

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,

Kumalu 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

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00041	B. WING		05/15/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
OAK HIL	LS LIVING CENTER		HTH STREET M, MN 56073			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLET DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a	hether a violation has been				
	that was violated du corrected. You may request a that may result from orders provided that	hearing on any assessments n non-compliance with these t a written request is made to				
		hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are		Minnesota Department of Health documenting the State Licensing Correction Orders using federal Tag numbers have been assigned Minnesota state statutes/rules for Homes.	g I software. ed to	

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

TITLE

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	
		00041	B. WING		05/15/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
	LS LIVING CENTER		HTH STREE 4, MN 56073	-		
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2 000	Continued From pa	ige 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure prod completion date, th corrected prior to electronic departm On May 12th, 13th, surveyors of this De above provider and orders are issued. electronic plan of cor reviewed these ord they will be complet Minnesota Departm the State Licensing federal software. Ta assigned to Minness Nursing Homes. The assigned tag n column entitled "ID statute/rule out of cor "Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follow are the Suggested Time period for Cor PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA	14th, and 15th, 2014, epartment's staff, visited the I the following correction Please indicate in your orrection that you have ers, and identify the date when ted. The tof Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for umber appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection. ARD THE HEADING OF THE		The assigned tag number a far left column entitled "ID The state statute/rule numb corresponding text of the st out of compliance is listed in "Summary Statement of De column and replaces the "T portion of the correction or column also includes the f are in violation of the state a statement, "This Rule is not evidenced by." Following t findings are the Suggested Correction and the Time Pe Correction. PLEASE DISREGARD THE THE FOURTH COLUMN W STATES, "PROVIDER'S PL CORRECTION." THIS APP FEDERAL DEFICIENCIES WILL APPEAR ON EACH F THERE IS NO REQUIREM SUBMIT A PLAN OF CORF VIOLATIONS OF MINNES STATUTES/RULES.	Prefix Tag." ber and the ate statute/rule in the ficiencies" o Comply" ler. This indings which statute after the the surveyors Method of briod For E HEADING OF /HICH AN OF LIES TO ONLY. THIS PAGE. ENT TO RECTION FOR	

STATEMEN	Dta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00041	B. WING		05/15/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OAK HIL	LS LIVING CENTER		HTH STREET M, MN 56073	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
	completed at the tin An investigation of	nt investigation(s) were also ne of the recertification survey complaint H5490013 was mplaint was not substantiated				
2 265	MN Rule 4658.008 Resident Health Sta	5 Notification of Chg in atus	2 265			
	policies to guide sta physicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the	ast develop and implement aff decisions to consult an assistants, and nurse known, notify the resident's or an interested family ent's acute illness, serious At a minimum, the director of and the medical director or an must be involved in the se policies. The policies must address at least the tion times for:				
		involving the resident which has the potential for requiring on;				
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ation in health, mental, or in either life-threatening al complications;				
		ter treatment significantly, for discontinue an existing form				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00041	B. WING		05/	05/15/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	·		
OAK HIL	LS LIVING CENTER		HTH STREET M, MN 56073	NORTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 265	Continued From pa	age 3	2 265				
	of treatment due to begin a new form c	adverse consequences, or to f treatment;					
	D. a decision resident from the n	to transfer or discharge the ursing home; or					
	E. expected and unexpected resident deaths.						
	by: Based on observat review the facility fa interested family m	ent is not met as evidenced ion, interview and document ailed to notify the physician and ember of injury for 1 of 1 had pain in the right toe after	i				
	Findings include:						
	complained of pain she said she had re ran the wheelchair diagnoses including degenerative joint of pain and takes sch and oxycodone. Th	a 5/13/14 at 9:54 a.m., R94 in her right foot from a bruise eccived when staff accidentally over her right foot. R94 had g osteoarthrosis (arthritis), disease (DJD) and generalized eduled extra strength Tylenol he minimum data set (MDS) rated that R94 was cognitively					
	licensed practical n sock of the right for	tion on 5/14/14, at 2:00 p.m. hurse (LPN)-A removed R94's ot. The right great toe and next sh green in color and painful ed the great toe.					
	LPN-A indicated sh incident occurred.	on 5/14/14, at 1:15 p.m. we was unsure when the LPN-A stated, "She told the ed at night but she did not					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00041	B. WING		05/15/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
DAK HIL	LS LIVING CENTER		HTH STREET M, MN 56073	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 265	Continued From pa	ge 4	2 265			
	was not reported to (PCP) and was una	ter lunch". LPN-A confirmed it the primary care provider ble to verify whether the tified, stating "can't recall if I				
	LPN-A, indicated R 'hurting'. Documen LPN-A "her foot wa (wheelchair) when s her bed". Documen was noted when the	a dated 5/6/14 and authored by 94 complained of the right foor tation indicated R94 informed s run over by her w/c she was sitting on the edge of tation indicated discomfort to toes was palpated (touched) ad pain with movement of the				
	director of nursing (on 5/14/14, at 1:45 p.m. the (DON) verified he would have hysician would have been				
	Documentation, ind nurse who observe involved in the incid	cedure for Incident (Resident) licated the supervisor or staff d, discovered or directly lent complete a report and the t) and family will be notified.				
	director of nursing (with the medical dir procedures for whe changes in the resid staff. The DON or audits of resident re	HOD OF CORRECTION: The DON) or desigee could work ector to update policies and n to notify the physician of dent, and then could educate designee could also perform ecords to determine if the notified as appropriate.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00041	B. WING			15/2014
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
DAK HIL	LS LIVING CENTER		HTH STREET M, MN 56073	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From p	age 5	2 830			
2 830	MN Rule 4658.052 Proper Nursing Ca	20 Subp. 1 Adequate and are; General	2 830			
	custodial care, and individual needs at the comprehensive plan of care as de 4658.0405. A nurs of bed as much as written order from	re and treatment, personal and d supervision based on nd preferences as identified in e resident assessment and escribed in parts 4658.0400 and sing home resident must be out s possible unless there is a the attending physician that the ain in bed or the resident n bed.	d t			
	by: Based on observa review the facility f	tion, interview and document ailed to monitor and assess 1 4) reviewed who experienced				
	Findings include:					
	complained of pair she said she had r	n 5/13/14 at 9:54 a.m., R94 n in her right foot from a bruise received when staff accidentally r over her right foot. R94 stated n that, it hurts".				
	R94 she stated, "tl wheelchair. It hurts toes then it is OK ' type of pain. Durin 12:45, it was noted	n 5/14/14, at 12:45 p.m. with hey drove over it with the s to step on it. If I don't lift my '. R94 denied having any other ng an observation on 5/14/14 at d that R94 propelled the nallway with her left foot, veered	t			

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
	00041			05/	05/15/2014	
PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		10/2014	
LS LIVING CENTER			NORTH			
(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
Continued From pa	age 6	2 830	DEFICIEN			
	-					
(arthritis), degeneral generalized pain ar strength Tylenol an data set (MDS) dat	ative joint disease (DJD) and nd takes scheduled extra d oxycodone. The minimum ed 2/14/14 indicated that R94					
licensed practical n sock of the right for two toes were bluis	urse (LPN)-A removed R94's ot. The right great toe and nex h green in color and painful	t				
LPN-A indicated sh incident occurred. day girls it happene report it to me till af was not reported to (PCP) and was una	te was unsure when the LPN-A stated, "She told the ed at night but she did not fter lunch". LPN-A confirmed i the primary care provider able to verify whether the	t				
LPN-A, indicated R 'hurting'. Documen LPN-A "her foot wa (wheelchair) when her bed". Documen	94 complained of the right foo ntation indicated R94 informed is run over by her w/c she was sitting on the edge of ntation indicated discomfort	t				
but had no increase toe. The progress Bruise' dated 5/7/1 was monitored dail pain/tenderness, an	ed pain with movement of the notes titled 'Monitoring of 4-5/15/14, indicated the site y and included: site, color, nd shape/pattern.					
	PROVIDER OR SUPPLIER LS LIVING CENTER SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From particle to the right and bur medication cart. R94 had diagnoses (arthritis), degeneration generalized pain ar strength Tylenol and data set (MDS) data was cognitively intar During an observation licensed practical marks sock of the right foot two toes were bluis when LPN-A toucher During an interview LPN-A indicated shi incident occurred. day girls it happener report it to me till atar was not reported to (PCP) and was unark family had been no did ". The progress notes LPN-A, indicated R 'hurting'. Documert was noted when the but had no increased toe. The progress Bruise' dated 5/7/14 was monitored dail pain/tenderness, and	OF CORRECTION IDENTIFICATION NUMBER: 00041 00041 PROVIDER OR SUPPLIER STREET A LS LIVING CENTER 1314 EIC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 nex 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 i 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	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: INCUIDE OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE IS LIVING CENTER 1314 EIGHTH STREET NORTH NEW ULM, MN 56073 SUMMARY STATEMENT OF DEFICIENCIES (EACH OEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PREVIX TAG PROVIDER'S PLAN OF (EACH OCKRECTIVE AC CROSS-REFERENCED TO DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PREVIX TAG PROVIDER'S PLAN OF (EACH OCKRECTIVE AC CROSS-REFERENCED TO DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PREVIX TAG PROVIDER'S PLAN OF (EACH OCKRECTIVE AC CROSS-REFERENCED TO DEFICIENCY MUST BE PRECEDED BY FULL PREVIX Continued From page 6 to the right and bumped into the wall and medication cart. 2 830 2 Continued From page 6 to 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. 2 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 contirmed 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', her foot was run over by her w/c (wheelchair) when she was sitting on the edge of her bed". Documentation indicated R94 informed LPN-A' her foot was run over by her w/c (wheelchair) when she was sitting on the edge of	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: Convertex 00041 B. WING 05/ PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 1314 EIGHTH STREET NORTH NEW ULM, MN 56073 SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID REGULATORY OR LGC IDENTIFYING WRORMATON) ID 7430 CONTINUED FOR PLOAD Continued From page 6 2 830 Continued From page 6 2 830 Continued pain and takes scheduled extra Strengt 1/4/4 in dicated that R94 was cognitively intact. During an observation on 5/14/14, at 2:00 p.m. During an observation on 5/14/14, at 2:200 p.m. incident occurred. LPN-A touched the great toe and next two socy offit to mergin to burner provider (PC) 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 informed LPN-A, indicated Side M94 informed LPN-A, indicated GM94 informed the was not repowers provider (PCC) 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 to the right foot. Drive regensences dated 5/6/14 and provide	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00041	B. WING		05/15/2014	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	• • • • •	
OAK HIL	LS LIVING CENTER		HTH STREET M, MN 56073	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 830	Continued From pa	age 7	2 830			
	notes lacked any interventions that were implemented.					
	director of nursing expected that the p notified and that int	y on 5/14/14, at 1:45 p.m. the (DON) verified he would have physician would have been terventions, which included hould have been implemented.				
	reported she saw t declined an x-ray a indicated a follow-u scheduled for next	v on 5/15/14, at 12:00 p.m. R94 he nurse practitioner (NP) and it the hospital. R94 further up visit with the NP was week. R94 further confirmed continues when attempts to				
	Documentation, dir staff nurse observir involved in the incir report thoroughly a communicated to t	becedure for Incident (Resident) rects that the supervisor or ng, discovering or directly dent will complete the incident and completely and then he Case Manager, DON and (MD) and family will be				
	director of nursing and reeducate all s procedures to ensu issues are properly nursing or her desi	THOD OF CORRECTION: The or her designee could review staff on the policies and ure that all resident's health or monitored. The director of gnee could develop monitoring ongoing compliance.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	OF CORRECTION	IDENTIFICATION NOWIDER.	A. BUILDING: _		CON	
		00041	B. WING		05/	15/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OAK HIL	LS LIVING CENTER		HTH STREET M, MN 56073	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 895	Continued From pa	ige 8	2 895			
2 895	MN Rule 4658.052 Motion	5 Subp. 2.B Rehab - Range of	2 895			
	that is directed towa through positioning implemented and n comprehensive res of nursing services development of a n provides that: B. a resident wit receives appropriat	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the nursing care plan which the a limited range of motion the treatment and services to notion and to prevent further of motion.				
	by: Based on observati review the facility fa services to prevent motion (ROM) in th	ent is not met as evidenced ion, interview and document ailed to provide ongoing further decrease in range of e lower extremities for 1 of 2 riewed who had limited range				
	Findings include:					
	Alzheimer's disease vascular disease, a weakness. During r minimum data set (2/3/14 indicated R8 staff with transfers assistance with bec and personal hygie	with diagnoses which included e, osteoporosis, peripheral and generalized muscle record review, the quarterly (MDS) assessment dated 22 was totally dependent on and required extensive d mobility, dressing, toilet use, ne. The MDS assessment at R82 had functional limitation				

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NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
OAK HIL	LS LIVING CENTER		HTH STREET M, MN 56073	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 895	lower extremities. T	ge 9 The contracture risk 2/3/14 revealed a score of 13;	2 895			
	which indicated the potential to develop assessment indicat should be consider	higher the score, the greater				
	revealed R82 recei 5/1/13. The PT pla indicated R82 had is both lower extremit extension, with the tone and tightness. at risk for contractu further indicated: "F is lacking 25 degree knee is lacking 70 d	ical therapy (PT) notes ved PT services from 4/12/13 n of care dated 4/12/13 ncreased muscle tightness in ies (LE's) affecting knee left side affected by increased Due to the tightness R82 was res. The PT plan of care ROM: R (right) knee extension es of extension and the L (left) degrees of extension initaially ged light stretch was able to parees lacking."	5			
	Further review of P revealed a need for R82's left knee "as pt (patient) due to h	T notes dated 4/16/13 a prolonged stretch brace for manual stretch will not benefit her severe contractures and snee extension brace was				
	indicated R82's cur "Patient able to extension bra as noted: (1) PT w techniques to be im contractures of the	summary dated 5/1/13 rent level of function as: end knee to 50 degrees with ce." The long term goals were vill train the staff in stretching plemented daily to prevent bilat (bilateral) knees and vith the EZ stand and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
	LS LIVING CENTER		HTH STREET M, MN 56073	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 895	contractures and in transfer method. T indicated: "Patient l extended periods of Therefore, the need and nursing can no of the brace. Nursi proper donning and Review of the nursi 5/29/13 at 1:45 p.m have quarter sized reddened. Will inia area." The nursing at 2:41 p.m. indicat (occupational thera and abrasions. OT and have NP (nurs once abrasions hea heal for new orders nursing progress m "Dc'd monitoring fo scab is off of knee limits)." R82's reco no follow-up with th healed was found. During interview or spouse/family mem been performing pa (PROM) to R82's u she was discharge FM-D confirmed th him with PROM tra never been trained	nprove use of the EZ stand The discharge summary further has tolerated the brace for of time in supine, sidelying. d for physical therapy is limited ow take over for the placement ing staff has been trained in d doffing of knee brace." ing progress notes dated n. revealed: "Patient noted to abrasion on left knee. Area is ate [sic] flowsheet to monitor progress note dated 5/29/14 ted: "Writer spoke with PT/OT apy) regarding residents brace stated to put brace on hold e practitioner) give new order aled. Will await abrasion to s. Further review of the otes dated 6/17/13 indicated: r skin redness, Resolved. skin WNL (within normal ord was reviewed further and he NP once the abrasion was n 5/14/14 at 11:24 a.m., R82's nber (FM)-D stated he had assive range of motion pper extremities (UE's) since d from therapy [6/17/13]. e OT department had provided ining for R82's UE's but had to do PROM to her LE's. is unsure if therapy was				
magazia D		a 5/14/14, at 1:15 p.m., nursing ated that PROM to the lower				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00041	B. WING		05/15/2014		
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	r ADDRESS, CITY, STATE, ZIP CODE				
DAK HIL	LS LIVING CENTER		HTH STREET M, MN 56073	NORTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
extre		been performed with R82 for	2 895				
	PROM for R82 was	nonths. NA-B confirmed that no longer on the NA's and that R82 had not been in that long.					
	stated that R82 pre it wasn't worn very was "so tight". NA-/ during dressing but	5/15/14, at 1:02 p.m., NA-A viously wore a knee brace but long due to the fact her knee A stated PROM is attempted is difficult. NA-A confirmed for R82 had not been the					
	practical nurse (LPI to utilize a knee bra after a skin issue of LPN-B was unsure recommendations b	5/15/14 at 1:21 p.m., licensed N)-B confirmed that R82 used ace which was discontinued ccurred from the brace. whether any further by therapy had occurred discontinuation of the knee					
	director of nursing of further notes and/o from physical thera electronic record of after discontinuation	5/15/14 at 2:11 p.m., the confirmed there were no r recommendations evident py after 5/1/13 in the R82. The DON verified that n of the knee brace no further follow-up had occurred.					
	Director of Nursing policies and proced programs, educate any changes and a	THOD OF CORRECTION: The could review and revise the lures for range of motion the appropriate personnel in ppoint a designee to monitor ensure ongoing compliance.					
	TIME PERIOD FOR	R CORRECTION: Twenty-one					

Minnesc	ta Department of He	ealth				APPROVE
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00041	B. WING		05/	15/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 895	Continued From pa	age 12	2 895			
	(21) days.					
21015	MN Rule 4658.061 Requirements- Sa	0 Subp. 7 Dietary Staff nitary conditi	21015			
	procedures and co	conditions. Sanitary nditions must be maintained in a dietary department at all				
	by: Based on observat review the facility fa environment in the	ent is not met as evidenced ion, interview and document ailed to maintain a sanitary dietary area which had the 8 of 88 residents who were the kitchen.				
	Findings include:					
		ur of the dietary area on a. the following observations				
	food preparation ar heavy build-up of d gas knobs used to observed to be hea grease with balls of control panel. Furth the stove and food heavily soiled with f (2.) An Echo water to the wall by the di filter had a heavy a	en and stove in the kitchen rea was observed to have a ust on their top surfaces. The regulate fire temperature was avily soiled with dust and f dust noted under the lip of the her, the wheels and frame of warmer were noted to be food debris, dust and grease. r filter was observed mounted ishwashing loading area. The ccumulation of dust, fuzzy in obwebs noted on the back and racket and filter.				

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NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21015	Continued From pa	age 13	21015			
	observed to have e cooler fan casing a area was noted to l be visualized upon cooling fan was blo items stored in the (4.) The large stand preparation area w have food debris of agitator motor, and the mixer was cove and the DM stated	poler used for food storage was excess dust build-up on the and coolant feed lines. The have heavy dust which could entering the cooler. The owing across multiple food cooler. d mixer in the kitchen food as inspected and noted to n the mixer agitator arm, I frame. When first observed ered with a plastic garbage bag the mixer was clean. The DM nould have been cleaned after				
	p.m. she verified al stated she had kno the cleaning of the always been comp	th the DM on 5/12/14, at 4:10 Il of the findings. The DM own there was a problem with kitchen and realized it had not leted as scheduled. The DM een some problems with y.				
	kitchen environmer following findings w (1.) The top surface continued to have a on them. It was evi been wiped since in and rear surface w heavily soiled and (had brown residue	of the food preparation and nt on 5/14/14 at 11:15 a.m. the vere again observed: es of the oven and stove a coating of dust and grease dent the stove and oven had nitial observation but the center as missed and continued to be (2.) The large stand mixer still around base of motor the motor and agitator arm.				
	of the April and Ma	o.m. the DM submitted a copy y 2014 cleaning schedule. The had multiple areas of cleaning not signed off as completed.				

STATEMEN	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00041	B. WING	B. WING		15/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
OAK HIL	LS LIVING CENTER		HTH STREET M, MN 56073	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21015	Continued From pa	ge 14	21015			
		sed on the findings in the ed the cleaning was not being duled.				
	DM she verified the concern for her and confidence that the with the cleaning so identified areas of c	2 p.m. during interview with dietary cleaning was a d she verbalized lack of evening shift had complied chedules. The DM verified the concern had not been cleaned vide a sanitary environment fo d preparing foods.				
	The administrator v services or designed as necessary the po- regarding kitchen s dietary or designee all appropriate staff procedures. The dire	THOD OF CORRECTION: with the director of dietary ee(s) could review and revise olicies and procedures anitation. The director of (s) could provide training for on these policies and rector of dietary or designee assure staff are cleaning the				
	TIME PERIOD FOF Twenty-one (21) da					
21535	MN Rule4658.1315 Drug Usage; Gener	Subp.1 ABCD Unnecessary	21535			
	must be free from unnecessary drug i A. in excessive therapy; B. for excessiv C. without ade D. in the prese	al. A resident's drug regimen unnecessary drugs. An s any drug when used: dose, including duplicate drug e duration; quate indications for its use; of nce of adverse consequences dose should be reduced or	r			

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
OAK HIL	LS LIVING CENTER		HTH STREET M, MN 56073	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21535	discontinued. In addition to the d part 4658.1310, th with provisions in th Code of Federal Re 483.25 (1) found in Operations Manual Long-Term Care Fa Department of Hea Health Care Financ This standard is inc available through th	Irug regimen review required in e nursing home must comply ne Interpretive Guidelines for egulations, title 42, section Appendix P of the State I, Guidance to Surveyors for acilities, published by the acilities, published by the acilities, published by the state Administration, April 1992. corporated by reference. It is ne Minitex interlibrary loan atte Law Library. It is not				
	by: Based on observati interview the facility side effects of a blo	ent is not met as evidenced ion, document review and / failed to monitor the potential bod thinning medication for 1 or reviewed for unnecessary				
	and congestive hea the physician order Coumadin (an antio the blood and incre (milligrams) po (by and Tuesday, and (every Monday, Wee Saturday. The plan "Monitor/document areas, scratches, c and "Monitor/docum doctor) PRN (as ne	es including atrial fibrillation art failure (CHF). Review of s revealed R103 received coagulant medication that thins ases risk of bruising) 5 mg mouth) daily every Sunday Coumadin 7.5 mg po daily dnesday, Friday, and n of care (undated) included: /report any redness, open uts bruises to charge nurse", nent/report to MD (medical eeded) s/sx (signs/symptoms) that included bruising.				

STATEME	Dta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00041	B. WING		05/15/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
OAK HIL	LS LIVING CENTER		HTH STREET M, MN 56073	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	ge 16	21535			
	 p.m., R103 was obsthe anterior of the lebruise on the anteriar and bruising in the arrow of the lebruise on the anteriar and left arm which I draw. During interview on practical nurse (LPN a noted bruise, it is for the cause and if inches or if unable to incident report is comonitor the bruise at treatment administring resolved. LPN-A coccurrently being more stated that R103 bruc Couradin. After ob areas with the prese confirmed the bilates should have been recurrently common (Eaccount for some or noted the large bruit R103's left forearm whopper". During interview on nursing assistant (Nassisted R103 with identified the bruisir indicated she had reago", although could could be be areas with the prese confirmed the bilates should have been recurrently be account for some or noted the large bruit R103's left forearm whopper". 	finterview on 5/12/14 at 6:58 served with a large bruise on eff forearm, a nickel size or aspect of the right wrist, antecubital space of the right R103 attributed to a blood 5/15/14 at 9:43 a.m., licensed N)-A stated upon discovery of measured and investigated the bruise is larger than 3 to identify the cause, an impleted. Subsequently, staff and document on the ation record (TAR) until onfirmed there were no bruises hitored for R103. LPN-A uises easily due to (d/t) taking servation of R103's bruised ence of the surveyor, LPN-A eral bruising to R103's arms eported and monitored. d that R103 had been to the ER) recently which could f the bruises. After LPN-A se on the anterior aspect of she stated "That's a 5/15/14, at 9:52 a.m., IA)-A confirmed that she had morning cares and had ng to R103's arms. She eported this to a nurse "2 days dn't remember which nurse it NA-A further stated that R103 is from a blood draw.				

OF CORRECTION	DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00041	B. WING		05/	15/2014
ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
S LIVING CENTER		-	NORTH		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	ge 17	21535			
Review of R103's incident report dated 5/15/14 at 10:30 a.m. included: "Noted bruise antecubital space It. (left) arm color fading It (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.					
Director of Nurses of the importance of m and efficacy of press could be developed physician ordered C other side effects or monitored. A qualit be developed to rep	could inservice staff regarding nonitoring for the side effects scribed medications. A tool I for residents who have Coumadin so that bruising and ould be assessed and y assurance measure could port to the overall quality				
TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
		21685			
including walls, floo systems, and equip continuous state of with regard to the h well-being of the re	rs, ceilings, all furnishings, ment must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written				
by:					
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LI Continued From pa Review of R103's in 10:30 a.m. included space It. (left) arm of measures 1x1 cm (arm dark grey bruis (left) medial forearm reddish color. Rt. a further documentative was available for ref SUGGESTED MET Director of Nurses of the importance of m and efficacy of press could be developed physician ordered O other side effects of monitored. A quality be developed to rep committee the effect TIME PERIOD FOF (21) days. MN Rule 4658.1418 Housekeeping, Ope Subp. 2. Physical p including walls, floo systems, and equip continuous state of with regard to the h well-being of the ref routine maintenanc	ROVIDER OR SUPPLIER STREET AL S LIVING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 Review of R103's incident report dated 5/15/14 at 10:30 a.m. included: "Noted bruise antecubital space It. 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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.	ROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST S LIVING CENTER 1314 EIGHTH STREET NEW ULM, MN 56073 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 17 21535 Review of R103's incident report dated 5/15/14 at 10:30 a.m. included: "Noted bruise antecubital space It. (left) arm color fading It (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. 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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00041	B. WING		05/15/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
DAK HIL	LS LIVING CENTER		GHTH STREET M, MN 56073	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21685	Continued From pa	ige 18	21685			
		dietary area, including the uipment, which had the				
	Findings include:					
	were made: (1.) The floor drain room near the dish a build-up of brown surrounding floor til on the floor tiles wa matter. This was lo the dirty dishes wer The dietary manage been problems with and the floor had be cleaning had been approximately a mo heavy buildup of wh and along the wall the dishwasher are the soiled area whe processed to the are dishwashing area w handled. Undernear dishwashing area, th heavy buildup of a (2.) The handwash the dishwashing are of a white/brown su	a. the following observations located in the dishwashing washer was observed to have substance on the grate and les. The periphery of the drain as coated with a thick white cated next to the area where re placed into the dishwasher. er (DM) verified there had the drain for about a month een mopped but no deep completed in this area for onth. In addition, there was a hite substance on floor tiles extending the entire length of a. This area extended from ere the dirty dishes were rea on the clean side of the where clean dishes were ath the clean side of the he floor drain also showed white and brown substance. hing sink, located across from ea, had a heavy accumulation distance on floor next to this th the soap dispenser. A large ved blowing air underneath a and was located so it had				
	dishwashing area w handled. Undernea dishwasher area, th heavy buildup of a (2.) The handwash the dishwashing are of a white/brown su sink and underneat floor fan was obser the dishwasher are contact with the floo (3.) The floor grout	where clean dishes were ath the clean side of the the floor drain also showed white and brown substance. hing sink, located across from ea, had a heavy accumulation abstance on floor next to this th the soap dispenser. A large ved blowing air underneath a and was located so it had or substance.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00041			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING		05/	05/15/2014		
NAME OF PROVIDER OR SUPPLIER STREET AD			DDRESS, CITY, STATE, ZIP CODE				
OAK HIL	LS LIVING CENTER		HTH STREET M, MN 56073	NORTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21685	Continued From pa	ge 19	21685				
	was noted to be tar not soiled. The diet was heavily soiled a from just one day. (4.) The walk-in fre large football size ic motor and water lin in cardboard boxes under the ice ball. (5.) The dry storag have excess spillag shelf racks. There y and other substance and been left unatte had spilled or dripp ago and she though the residue build-up (6.) A fire alarm st outside of the dry s	The natural color of the grout in a reas where the grout was ary manager verified the floor and it was not due to build up bezer was noted to have a ce ball formed on the coolant es. The freezer contained food that were stored directly e room floor was noted to ge on the tiled floor under the was evidence that cooking oil es had leaked onto the floor ended. The DM stated that oil ed onto floor about a month in that was what had caused b. robe light located on the wall torage room was observed to th dust and cobwebs that were	ł				
	kitchen environmer 5/14/14 at 11:15 a.r again observed: (1.) The dry storage soiled with white/br floor underneath the facility stored cooki (2.) The fire alarm s dry storage room de heavy coating of du (3.) Two breaker bookitchen in food prep	strobe light on the wall by the oor remained soiled with a list and grime; and oxes located on the wall in the paration area were noted to o of dust and cobwebs on the					
	At 5/14/14 at 1:00 r	o.m. the DM submitted a copy					

DVIDER OR SUPPLIER S LIVING CENTER SUMMARY STA	00041 Street ad	B. WING				
LIVING CENTER		B. WING				
LIVING CENTER	STREET AD			05/	05/15/2014	
		DRESS, CITY, S	TATE, ZIP CODE			
SUMMARY STA			NORTH			
		I, MN 56073	PROVIDER'S PLAN OF	CORRECTION	(X5)	
	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLE DATE	
Continued From pa	ige 20	21685				
leaning schedule i rojects that were r 'he DM stated, bas itchen, she believe erformed as sched UGGESTED MET 'he dietary manage egarding the impor leaning schedule. vith the assistance ssure that floors, w naintained and on f the audit could b ssurance committ	not signed off as completed. sed on the findings in the ed the cleaning was not being duled. THOD OF CORRECTION: er could inservice staff rtance of maintaining the An audit could be developed of the maintenance staff to walls and equipment be a regular schedule. The result e reported to the quality ee.					
		21805				
esidents have the ourtesy and respe	right to be treated with ct for their individuality by					
y: Based on observati eview the facility fa	ion, interview and document ailed to treat 1 of 1 resident					
indings include:						
	rojects that were r he DM stated, bas tchen, she believe erformed as scher UGGESTED MET he dietary manage garding the impor- eaning schedule. ith the assistance ssure that floors, v laintained and on f the audit could b ssurance committ IME PERIOD FOR 21) days. IN St. Statute 144 esidents of HC Fa ubd. 5. Courteo esidents have the purtesy and respe mployees of or pe ealth care facility. his MN Requirements with the facility fa ased on observation experience.	 f the audit could be reported to the quality ssurance committee. IME PERIOD FOR CORRECTION: Twenty-one 21) days. IN St. Statute 144.651 Subd. 5 Patients & esidents of HC Fac.Bill of Rights ubd. 5. Courteous treatment. Patients and esidents have the right to be treated with purtesy and respect for their individuality by mployees of or persons providing service in a ealth care facility. his MN Requirement is not met as evidenced y: ased on observation, interview and document eview the facility failed to treat 1 of 1 resident 2111) in a dignified manner during the dining xperience. 	rojects that were not signed off as completed. the DM stated, based on the findings in the tchen, she believed the cleaning was not being erformed as scheduled. UGGESTED METHOD OF CORRECTION: the dietary manager could inservice staff agarding the importance of maintaining the eaning schedule. An audit could be developed ith the assistance of the maintenance staff to ssure that floors, walls and equipment be the audit could be reported to the quality ssurance committee. IME PERIOD FOR CORRECTION: Twenty-one 21) days. IN St. Statute 144.651 Subd. 5 Patients & esidents of HC Fac.Bill of Rights ubd. 5. Courteous treatment. Patients and ssidents have the right to be treated with ourtesy and respect for their individuality by mployees of or persons providing service in a ealth care facility. this MN Requirement is not met as evidenced y: ased on observation, interview and document eview the facility failed to treat 1 of 1 resident R111) in a dignified manner during the dining xperience. indings include:	rojects that were not signed off as completed. he DM stated, based on the findings in the tchen, she believed the cleaning was not being erformed as scheduled. UGGESTED METHOD OF CORRECTION: he dietary manager could inservice staff garding the importance of maintaining the eaning schedule. An audit could be developed ith the assistance of the maintenance staff to ssure that floors, walls and equipment be maintained and on a regular schedule. The result it the audit could be reported to the quality ssurance committee. IME PERIOD FOR CORRECTION: Twenty-one 11) days. IN St. Statute 144.651 Subd. 5 Patients & esidents of HC Fac.Bill of Rights ubd. 5. Courteous treatment. Patients and sidents have the right to be treated with burtesy and respect for their individuality by mployees of or persons providing service in a ealth care facility. his MN Requirement is not met as evidenced y: ased on observation, interview and document eview the facility failed to treat 1 of 1 resident X111) in a dignified manner during the dining xperience. indings include:	rojects that were not signed off as completed. the DM stated, based on the findings in the tchen, she believed the cleaning was not being erformed as scheduled. UGGESTED METHOD OF CORRECTION: the dietary manager could inservice staff ggarding the importance of maintaining the eaning schedule. An audit could be developed ith the assistance of the maintenance staff to ssure that floors, walls and equipment be anintained and on a regular schedule. The result i the audit could be reported to the quality ssurance committee. IME PERIOD FOR CORRECTION: Twenty-one ?1) days. IN St. Statute 144.651 Subd. 5 Patients & esidents of HC Fac.Bill of Rights ubd. 5. Courteous treatment. Patients and sidents have the right to be treated with ourtesy and respect for their individuality by mployees of or persons providing service in a ealth care facility. this MN Requirement is not met as evidenced y: ased on observation, interview and document type the facility failed to treat 1 of 1 resident R111) in a dignified manner during the dining xperience. indings include:	

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 000041			CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/15/2014		
		B. WING				
					05/	15/2014
	PROVIDER OR SUPPLIER		DRESS, CITY, ST ITH STREET			
DAK HIL	LS LIVING CENTER		I, MN 56073			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From page 21		21805			
	 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. 					
	R111 verbalized sh belt throughout the	on 5/14/14, at 2:00 p.m., e did not like wearing the gait meals. When R111 was her emotionally or physically, ike it."				
	3/28/14 indicated m R111's plan of care R111 is at risk for fa problem. One of th indicated the use o included a gait belt restrictive device on	nimum Data Set (MDS) dated noderate cognitive impairment. dated 5/16/2013 indicated alls related to gait and balance the interventions included f adaptive appliances which and to ensure the least rappliance used. There was notion that a gait belt was t meal times.				
	(DON) on 5/15/14, that he expected st	with the director of nursing at 9:30 a.m. it was indicated aff to remove the gait belt he using it when possible.				
	was requested and 10/2013 did not spe belt, but instructed	y's policy on using a gait belt received. The policy dated ecify when to remove the gait employees that gait belt usage assistance with the resident obility.				
	SUGGESTED MET	HOD OF CORRECTION:				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DAT	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00041	B. WING		05/	15/2014
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AK HIL	LS LIVING CENTER		HTH STREET M, MN 56073	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From page 22		21805			
	in-service all staff or residents with responses Assessment and As develop a system to care and services to	sing or social services could on the need to treat all ect and dignity. The Quality ssurance committee could o audit employees for dignified oward residents in the facility. R CORRECTION: Twenty-one				