#### CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL TE SURVEY AGENCY		SIKJ cility ID: 00799
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245540  2.STATE VENDOR OR MEDICAID NO.     (L2) 438670100  5. EFFECTIVE DATE CHANGE OF OWNERSHI     (L9) 02/01/2017	(L3) (L4) (L5)	3. NAME AND ADDRESS OF FACILITY (L3) HENNING REHABILITATION & HEA (L4) 907 MARSHALL AVENUE, PO BOX (L5) HENNING, MN  7. PROVIDER/SUPPLIER CATEGORY			4. TYPE OF ACTION:  1. Initial 3. Termination 5. Validation 7. On-Site Visit 8. Full Survey After Con	7 (L8)  2. Recertification  4. CHOW  6. Complaint  9. Other	
6. DATE OF SURVEY 05/18/2018 8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) <b>02</b> SI	NF/NF/Dual NF/NF/Distinct	05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	09 ESRD 10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING I	DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds 35 13.Total Certified Beds 35	(L18)	A. In Compliance Program Re Compliance1. Ac B. Not in Comp	quirements	am	And/Or Approved Waivers Of Th  2. Technical Personnel  3. 24 Hour RN  4. 7-Day RN (Rural SNF)  5. Life Safety Code  * Code: A*	6. Scope of Service 7. Medical Direct	or
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF  35  (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARKS (IF A	APPLICABLE SHO	W LTC CANCEL	LATION DATE)	:			
17. SURVEYOR SIGNATURE  Gail Anderson, Unit Supervis	sor	Date : 05	5/22/2018	(L19)	18. STATE SURVEY AGENCY A		Date:05/22/2018 (L20
PART II  19. DETERMINATION OF ELIGIBILITY  _X 1. Facility is Eligible to Participate 2. Facility is not Eligible	(L21)	20. COMP	BY HCFA RE PLIANCE WITH O HTS ACT:			ncial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCF	FA-1513)
OF PARTICIPATION B. <b>04/01/1990</b>	C AGREEMENT EGINNING DATE  41)	24.	LTC AGREEMI ENDING DATE (L25)		26. TERMINATION ACTION:  VOLUNTARY 00  01-Merger, Closure  02-Dissatisfaction W/ Reimbursement	05-Fail to Mee	RY et Health/Safety
A.	LTERNATIVE SAI Suspension of Ad Rescind Suspension	missions:	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider St 00-Active	atus Change

30. REMARKS

DETERMINATION APPROVAL

(L31)

(L33)

29. INTERMEDIARY/CARRIER NO.

32. DETERMINATION OF APPROVAL DATE

01111

05/11/2018

(L28)

(L32)

28. TERMINATION DATE:

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245540

May 22, 2018

Mr. Patrick Krejci, Administrator Henning Rehabilitation & Healthcare Center 907 Marshall Avenue, PO Box 57 Henning, MN 56551

Dear Mr. Krejci:

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 May 4, 2018 the above facility is recommended for:

35 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 35 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,

Joanne Simon, Enforcement Specialist Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 22, 2018

Mr. Patrick Krejci, Administrator Henning Rehabilitation & Healthcare Center 907 Marshall Avenue, PO Box 57 Henning, MN 56551

RE: Project Number S5540028

Dear Mr. Krejci:

On April 17, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 29, 2018. 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 May 18, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 7, 2018 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 March 29, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 4, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 29, 2018, effective May 4, 2018 and therefore remedies outlined in our letter to you dated April 17, 2018, 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,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL E SURVEY AGENCY		ID: SIKJ Facility ID: 00799
1. MEDICARE/MEDICAID PROVID (L1) 245540 2.STATE VENDOR OR MEDICAID N (L2) 438670100		3. NAME AND AD (L3) HENNING F (L4) 907 MARSH (L5) HENNING, 1	REHABILITAT ALL AVENUE	TION & HE	ALTHCARE CENTER 57 (L6) 56551	4. TYPE OF ACT	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9) <b>02/01/2017</b>		7. PROVIDER/SU	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit  8. Full Survey At	9. Other fter Complaint
6. DATE OF SURVEY 03/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	29/2018 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END	DING DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds	35 (L18)	Compliano		S:	And/Or Approved Waivers Of T 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN	6. Scope o 7. Medical	f Services Limit  Director
13.Total Certified Beds	35 (L17)	X B. Not in Cor Requirements	mpliance with Prog and/or Applied Wa	_	5. Life Safety Code  * Code: <b>B*</b>	9. Beds/Ro (L12)	oom
14. LTC CERTIFIED BED BREAKD	OWN	1			15. FACILITY MEETS		
18 SNF 18/19 SNI 35	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICABL	E SHOW LTC CANCI	ELLATION DATE	E):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Denise Erickson, HI	E NE II		05/09/2018	(L19)	Douglas S. Larson, Enforcement Specialist 05/10/2018		
	PART II - TO BE	COMPLETED	BY HCFA R	EGIONAL	OFFICE OR SINGLE ST	TATE AGENCY	
19. DETERMINATION OF ELIGIBII  1. Facility is Eligible to			MPLIANCE WITH GHTS ACT:	CIVIL	<ol> <li>Statement of Financial Solvency (HCFA-2572)</li> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>Both of the Above :</li> </ol>		
2. Facility is not Eligi	(L21)						
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEN	MENT	26. TERMINATION ACTION:		(L30)
OF PARTICIPATION <b>04/01/1990</b>	BEGINNING	DATE	ENDING DA	ГЕ	VOLUNTARY 01-Merger, Closure		to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursen		to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI  A. Suspension	VE SANCTIONS n of Admissions:			03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	07-Pro	vider Status Change
(L27)	B. Rescind Sus	pension Date:	(L44)			00-Act	ive

(L45)

30. REMARKS

DETERMINATION APPROVAL

(L31)

(L33)

29. INTERMEDIARY/CARRIER NO.

32. DETERMINATION OF APPROVAL DATE

01111

(L28)

(L32)

28. TERMINATION DATE:

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 17, 2018

Mr. Patrick Krejci, Administrator Henning Rehabilitation & Healthcare Center 907 Marshall Avenue, PO Box 57 Henning, MN 56551

RE: Project Number S5540028

Dear Mr. Krejci:

On March 29, 2018, 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 electronically delivered CMS-2567 whereby corrections are required.

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 an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140 Fax: (218) 332-5196

#### **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 May 8, 2018, 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 May 8, 2018 the following remedy will be imposed:

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

#### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

#### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

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

#### Original deficiencies not corrected

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

### Original deficiencies not corrected and new deficiencies found during the revisit

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

#### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 29, 2018 (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

Henning Rehabilitation & Healthcare Center April 17, 2018 Page 5

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 September 29, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Henning Rehabilitation & Healthcare Center April 17, 2018 Page 6

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

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist

Minnesota Department of Health

Mostaly Gra

Health Regulation Division

Program Assurance Unit

phone 651-201-4117 fax 651-215-9697

email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

PRINTED: 05/09/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245540	B. WING		03	/29/2018
	PROVIDER OR SUPPLIER  G REHABILITATION 8	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZI 907 MARSHALL AVENUE, PO BO HENNING, MN 56551	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
E 000	Initial Comments		E 0	00		
F 000	Emergency Prepar conducted on 3/26/ recertification surve with the Appendix 2 Requirements.	liance with CMS Appendix Z edness Requirements, was /18, to 3/29/18, during a ey. The facility is in compliance Z Emergency Preparedness	F 0	00		
	was completed at y Department of Hea was in compliance	h 3/29/18, a standard survey your facility by the Minnesota lith to determine if your facility with requirements of 42 CFR 3, and Requirements for Long s.				
	as your allegation of Department's acce enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required be first page of the CMS-2567 ic submission of the POC will tion of compliance.				
	on-site revisit of you validate that substa		F 5	50		5/4/18
	self-determination, access to persons	nt Rights. right to a dignified existence, and communication with and and services inside and including those specified in				

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

(X6) DATE

**Electronically Signed** 

04/25/2018

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.

TITLE

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245540	B. WING		03/29/2018	
	PROVIDER OR SUPPLIER  G REHABILITATION 8	HEALTHCARE CENTER	9			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION	
F 550	with respect and diresident in a mannipromotes maintenather quality of life, reindividuality. The far promote the rights  §483.10(a)(2) The access to quality caseverity of condition must establish and practices regarding provision of service residents regardles  §483.10(b) Exercise The resident has the rights as a resident or resident of the USAB3.10(b)(1) The resident can exercise interference, coercifrom the facility.  §483.10(b)(2) The free of interference reprisal from the facility.  §483.10(b)(2) The free of interference reprisal from the facility.  This REQUIREME by:  Based on observa	cility must treat each resident gnity and care for each er and in an environment that ance or enhancement of his or ecognizing each resident's acility must protect and of the resident.  facility must provide equal are regardless of diagnosis, n, or payment source. A facility maintain identical policies and g transfer, discharge, and the es under the State plan for all as of payment source.  The of Rights.  The right to exercise his or her to of the facility and as a citizen	F 550	Does not include plans to monitor performance to make sure that sol		
		(R1) observed during catheter		are sustained. include visual auditicaresperineal and or cares with	ng of	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED	
<b>245540</b> B. WING		03/29/2018	
NAME OF PROVIDER OR SUPPLIER STREET	T ADDRESS, CITY, STATE, ZIP CODE	00/20/2010	
HENNING REHABII ITATION & HEAI THCARE CENTER	ARSHALL AVENUE, PO BOX 57 IING, MN 56551		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 550 Continued From page 2 F 550 pat	itients		
diagnoses which included cerebral vascular accident (CVA), diabetes mellitus and obstructive uropathy. R1 was cognitively intact and required extensive assistance with bed mobility, dressing and hygiene. R1's MDS further identified R1 utilized an indwelling catheter.  R1's care plan, updated 3/24/18, indicated R1 used an indwelling catheter related to a neurogenic bladder. The care plan indicated R1 would be free from catheter-related trauma and directed staff to position catheter bag and tubing below the level of the bladder and away from entrance room door. R1's care plan further identified R1 had tested positive for C-Diff (clostridium difficile; bacterial infection with symptoms of watery diarrhea) and R1 was on contact precautions.  The facility nursing assistant care sheet, untitled, undated, indicated R1 was on contact precautions for C-Diff and was incontinent of bowel. The care sheet also identified R1 had a foley catheter.  On 3/27/18, at 8:33 a.m. R1 was lying on back on his bed. R1's catheter bag was attached to the bed frame, uncovered. A moderate amount of dark amber urine was present in the bag and was visible from the hall, while R1's room door was opened wide to the hall.	nis Plan of Correction constitutes mitten allegation of compliance for the ficiencies cited. However, submiss this Plan of Correction is not an Imission that a deficiency exists or the was cited correctly. This Plan of correction is submitted to meet equirements established by state anderal law.  It is the policy of this facility to treath resident with respect and digniting for each resident in a manner are environment that promotes antenance or enhancement of his ear quality of life. Some of the many fact this has been achieved for resident is by ensuring resident has catheting covered always, supplies in room aff to do cares appropriately and in the earn and professional manner or griffed care. In this case, after the reveyor reported finding resident catheting on floor and visible to anyone was immediately catheter was placed in propriate bag and hooked to bed from witnessing incontinent care on the resident R1 it was noted incontinuous were passed to another staff or sident face. This immediately was viewed, and all staff reminded to comote dignity and respect and ensited acres in professional manner.  Because all residents that reside	ne sion that sid eat y and nd in or ways ent ser n for ovide theter alking in an rame. tinent ver ure hem	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245540	B. WING			03/2	29/2018
	PROVIDER OR SUPPLIER  G REHABILITATION &	HEALTHCARE CENTER		9(	TREET ADDRESS, CITY, STATE, ZIP CODE 07 MARSHALL AVENUE, PO BOX 57 IENNING, MN 56551		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	visible through the catheter bag was u the bag was rested On 3/28/18, at 10:1 back in his bed, concatheter tubing was his blanket, down to unhooked from the directly on the floor resting on the floor resting on the floor room, emptied R1's to perform perineal a large amount of the directly on the floor and leaked onto his pad under him and garbage can was obed, near the head assisted R1 to his leaded on the brief. The brief had loose stool, visible the brief. NA-E han moved it over R1's garbage can, locate the floor next to the used several disposperineal area, butto brown stool. Each handed the soiled wit below R1's face in observed multiple thand wipes, then look Registered nurse (Fisupply of additional to NA-E and NA-B, incontinence care, perineal area and the wipes over to NA-B.	door from the hallway. R1's ncovered, the bottom 1/3 of directly on the floor.  6 a.m. R1 remained on his vered with linens. His sobserved running from under the catheter bag, which was bed, uncovered and rested with the lower 1/3 of the bag NA-B and NA-E entered his catheter bag, then proceeded cares. R1 was incontinent of lark brown loose stool, which thighs, the cloth incontinence his sheet. A tan, plastic bserved on each side of R1's of the bed. NA-E and NA-B eft side then removed his I a large amount of brown, on the inside and outside of ded the dirty brief to NA-B who head and placed it in the ed directly below R1's face, on left side of his bed. NA-E sable wipes to cleanse R1's cks and thighs of the dark time she used a wipe, she wipe to NA-B, who then placed in the garbage can. R1 was mes looking at the soiled brief	F 5	550	potentially affected by the cited defi No other residents currently have a catheter. Care sheets also reinforce practice. All staff were reminded to sure bags are in all wastebaskets a use and pre-gather supplies and equipment prior to cares to ensure done according to standards taugh nursing aide classes. When staff no resident not having garbage can, galiners or catheter bags they are immediately to correct the solution resident. Current residents were auby director of nursing to ensure the supplies needed, catheters covered that any cares were completed to put the resident rights. No other resident were affected. The Policy and Proceed for quality of life was reviewed.  3. To enhance currently compliant operations and under the direction director of nurses, on 4/24/2018 all attended in-service training regarding resident rights, quality of care, dign proper catheter/incontinence care. training will emphasize the important understanding covering catheter baprivacy and respect, the example of care witnessed and review the disrest would cause to anyone, and the importance of supplies being availated and in place for next person providing care. Residents should be encourated express their concerns regarding concerns the encourated express their concerns regarding concerns the encourated express their concerns regarding contents.  4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision implemented under the super	ed this make fiter being in ote any arbage for any dited y had and romote of the staff ity, and The of igs for f the espect ble ing ged to are and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245540	B. WING		03/2	29/2018	
	PROVIDER OR SUPPLIE  G REHABILITATION	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIF 907 MARSHALL AVENUE, PO BO HENNING, MN 56551	CODE		
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F 550	they assisted him  On 3/29/18, at 3: was not good to help products placed of incontinence care preferred staff to other side of the leface.  On 3/28/18, at 2:0 noticed the places she completed R confirmed she had the soiled brief ar confirmed the soi placed in front of NA-B indicated she had ling of the soi indicated she had happy if someone this manner and a had been unawar and rested on the On 3/28/18, at 2:3 she entered the recatheter bag was slipped out the claware there were but indicated she soiled, with brown the garbage can onew liner in it. She think of the positing R1's incontinence a concern to hand	34 p.m. R1 indicated he felt it have the garbage can with soiled close to his face during his es. He indicated he would of use the garbage can on the oed, not the one in front of his object, not the garbage can after a soiled wipes during cares and led brief and soiled wipes were object, and the object of his object, and have a soiled him she would not of been a had treated her grandparent in a pologized. NA-B indicated she had treated her grandparent in a pologized. NA-B indicated she had treated her grandparent in a pologized. NA-B indicated she had not noticed the on the floor, but felt it may have oth bag. NA-E stated she was two garbage cans in R1's room, had handed the used items in loose stool, to NA-B because on R1's right side did not even on of the garbage can during a cares. NA-E confirmed it was did the soiled brief and soiled did place them into the garbage	F 5	DON to monitor resident of dignity, and incontinence/of The DON or designee will audits per week x 4 weeks bags, having proper supplied and to ensure catheter/income are done appropriately. The weekly for 4 weeks ensure with best practices. Any displayed be corrected on the spot, of the quality-assurance commit further review or correctives. DON will be responsible.	catheter care. complete 2 s on catheter des in rooms, continent cares en 1 audit e staff comply eficiencies will and the findings hecks will be d at the monthly tee meeting for e action.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  G REHABILITATION 8	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 550	(DON) indicated R covered with a clott been aware R1's cauncovered in the paindicated he did no she informed him it only for his dignity, the facility. DON in nursing staff to han appropriately, plan supplies/equipmen she felt placing so	age 5 s p.m. director of nursing 1's catheter bag should be a bag at all times, and had atheter bag had been ast. DON indicated R1 t care if it was uncovered, but a needed to be covered, not but for residents and visitors in dicated she would expect dle soiled products cares to ensure the correct t were available. She indicated field items directly in front of a ang incontinence cares was not	F 55	0		
F 623 SS=D	dated 12/27/17, incomparison treated with dignity meaning resident was maintaining and end and self-worth. Der standards of care to prohibited. The polithelp residents keep Notice Requirement CFR(s): 483.15(c)(s) §483.15(c)(s) Notice Regular resident, the facility (i) Notify the resident representative(s) of the reasons for the language and manifacility must send as	e before transfer. nsfers or discharges a	F 62	3		5/4/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER  G REHABILITATION &	R HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		
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F 623	Long-Term Care O (ii) Record the reast discharge in the reactordance with parand (iii) Include in the mand (iii) Include in the mand (iii) Except as specific (c)(8) of this section discharge required made by the facility resident is transfer (ii) Notice must be before transfer or (A) The safety of in be endangered und this section; (B) The health of in be endangered, und this section; (C) The resident's allow a more immeduate paragraph (c) (D) An immediate frequired by the resunder paragraph (c) (E) A resident has days.  §483.15(c)(5) Continuities and the following include the following	mbudsman. sons for the transfer or sident's medical record in aragraph (c)(2) of this section; notice the items described in it this section.  In gof the notice. In gof the notice of transfer or under this section must be y at least 30 days before the red or discharged. In made as soon as practicable discharge when- individuals in the facility would der paragraph (c)(1)(i)(C) of individuals in the facility would ider paragraph (c)(1)(i)(D) of individuals in the facility would ider paragraph (c)(1)(i)(D) of individuals in the facility would ider paragraph (c)(1)(i)(D) of individuals in the facility would ider paragraph (c)(1)(i)(D) of individuals in the facility would ider paragraph (c)(1)(i)(D) of individuals in the facility would ider paragraph (c)(1)(i)(D) of individuals in the facility for 30 individuals in	F 62	3		

Facility ID: 00799

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245540	B. WING _		03	/29/2018
	PROVIDER OR SUPPLIER  G REHABILITATION 8	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 907 MARSHALL AVENUE, PO BOX S HENNING, MN 56551	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 623	(iv) A statement of including the name and telephone numreceives such requite obtain an appeal completing the form hearing request; (v) The name, additelephone number Long-Term Care O (vi) For nursing fact and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone rumber the protection and advelopmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone in telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection and developmental disabilities, the mait telephone number the protection an	the resident's appeal rights, address (mailing and email), aber of the entity which ests; and information on how form and assistance in and submitting the appeal ress (mailing and email) and of the Office of the State mbudsman; ility residents with intellectual disabilities or related disabilities or related iling and email address and of the agency responsible for advocacy of individuals with abilities established under Part ental Disabilities Assistance ct of 2000 (Pub. L. 106-402, C. 15001 et seq.); and cility residents with a mental disabilities, the mailing and telephone number of the efor the protection and uals with a mental disorder the Protection and Advocacy riduals Act.  Inges to the notice. In the notice changes prior to be or or discharge, the facility cipients of the notice as soon as the updated information	F 62	3		

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· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	l'	(X3) DATE SURVEY COMPLETED	
		245540	B. WING		03/29	9/2018
	PROVIDER OR SUPPLIER  GREHABILITATION	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551	CODE	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 623	Continued From part to the State Survey State Long-Term Countries the facility, and the well as the plan for relocation of the red 483.70(I). This REQUIREMED by: Based on interview facility failed to not initiated discharges R124, R22) who were remarked to the facility failed to not initiated discharges R124, R22) who were remarked to the facility failed to not initiated discharges R124, R22) who were remarked to the facility failed hypertension and were remarked to the hospital at the R124's quarterly M diagnoses which in	age 8  y Agency, the Office of the Care Ombudsman, residents of a resident representatives, as a the transfer and adequate esidents, as required at §  ENT is not met as evidenced and and document review, the ify the ombudsman of facility is for 3 of 3 residents (R6, were discharged to the hospital.  Inimum Data Set (MDS) dated diagnoses which included weakness.  The set of the office of the decided and R6 had been admitted as a serie of the control of	F 623	DEFICIENCY)	my the sion  r that of  nd  ort all ere all was the buld be noted ntation hat	
	presented with were saturation of 83%, hospital emergence 10:25 p.m. facility them R124 had be hospital for admission congestive heart face	Notes dated 3/14/18, R124 akness and decreased oxygen had been sent R124 to y room (ER) for evaluation. At received a phone call informing en transferred to St. Cloud sion for pneumonia and ailure (CHF). Record identified diagnoses		transfers/discharges was updated, so were educated, reminders sent to no stations with policy and requirement 2. Because all residents that reside the facility do either discharge or havisits to ER, all are potentially affected the cited deficiency. Immediately all residents being transferred or discharge or eviewed and update was note ombudsman. When staff note any	ursing s. e in ve ed by	

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	PROVIDER OR SUPPLIER  REHABILITATION 8	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  907 MARSHALL AVENUE, PO BOX 57  HENNING, MN 56551				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 623	which included ano and chronic obstruct R22's Progress Nothad been sent to enadmitted for aspiral Review of R6, R12d lacked documentat facility initiated embeen sent to the Lo Ombudsman.  On 3/28/18, at 1:10 (LSW)-A confirmed ombudsman of R6, LSW-A confirmed hinclude notifying the unless it was a "report of the conformal dimensional dimensi	xic brain damage, seizures ctive pulmonary disease.  tes on 3/4/18, indicated R22 mergency department and	F 6		resident leaving they are aware of notification needed and in turn mak appropriate note in resident chart. The residents were audited by director of nursing to ensure all had appropriate notification in place. No other residents were affected. The Policy and Proof for transfers/discharges was revised 3/29/2018; reviewed on 4/17/2018.  3. To enhance currently complian operations and under the direction director of nurses, on 4/24/2018 all will attended in-service training regular this policy and the importance of normoudsman. The training will empthis is to be done as soon as possification is critical.  4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision SW in conjunction with DON to mo any transfers and discharges to enappropriate notification given. The designee will complete 2 audits per x 4 weeks on residents that have transferred or discharged, then 1 a weekly for 4 weeks ensure staff cowith current policy. Any deficiencies corrected on the spot, and the findithe quality-assurance checks will be documented and submitted at the requality-assurance committee meetifurther review or corrective action.	Current of te ents edure d on t of the staff arding otifying whasize ole for r  of the nitor sure SW or week udit mply s will be ngs of e monthly		
F 625 SS=D		Policy Before/Upon Trnsfr 1)(2)	F 6	25	5. SW will be responsible for this	POC.	5/4/18	

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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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
F 625	§483.15(d)(1) Notion nursing facility transthe resident goes on nursing facility must the resident or resispecifies- (i) The duration of any, during which the return and resume facility; (ii) The reserve been plan, under § 447.4 (iii) The nursing facility and periods, where the plan is periods, where the plan is periods, where the plan is periods in the time of transfer hospitalization or the provider of the time of transfer hospitalization or the provider of the provider is pecifies the duration described in paragonal transfer hospitalization or the provider of the p	of bed-hold policy and returnate before transfer. Before a sfers a resident to a hospital or on therapeutic leave, the st provide written information to dent representative that the state bed-hold policy, if the resident is permitted to residence in the nursing dipayment policy in the state 40 of this chapter, if any; cility's policies regarding which must be consistent with this section, permitting a land on specified in paragraph (e)(1)	F 625	5	
	facility failed to ens representative was policy at the time o	v and document review, the sure the resident or resident's informed of the bed hold f hospitalization for 2 of 3 ) reviewed for hospitalization.		This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submored this Plan of Correction is not an admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by state	the ssion or that

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION NG		E SURVEY PLETED
		245540	B. WING		03/	29/2018
NAME OF I	PROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP CO		
HENNIN	G REHABILITATION	& HEALTHCARE CENTER		907 MARSHALL AVENUE, PO BOX 5 HENNING, MN 56551	7	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 625	Continued From p	page 11	F 6	25		
	Review of R22's Adiagnoses which is seizures and chrodisease.  R22's Progress Nad been sent out admitted for aspir to the facility on 3.  The medical recorbed hold informat R22, or given to Rather time of transfecontact the reside bed hold policy.  On 3/29/18. at 2:4 clinical services (Policy was not offer representative at 2:4 clinical services)	Admission Record indicated included anoxic brain damage, onic obstructive pulmonary  Notes on 3/4/18, indicated R22 at to emergency department and ation pneumonia. R22 returned /8/18.  Indicated documentation that ion was sent to the hospital for R22's resident representative at er to the hospital, or attempts to ent representative to offer the RDCS) confirmed the bed hold ered to R22 or R22's resident the time of transfers to acute facility was working on updating		federal law.  1. It is the policy of this faci bed hold consent obtained fropy given to hospital receive and that POA also receives of R22 were sent to the hospital indication bed hold policy was hospital or POA per regulation surveyor reported lack of door that this occurred, it was not practice had not yet been revimplemented appropriately with law and the modern and the policy and proceive holds was updated, staff were reminders sent to nursing state policy and requirements.  2. Because all residents that the facility make visits to hose occasion or go on therapeutian are potentially affected by the deficiency. Immediately all retransferred or on leave were updated bed hold policy give staff note any resident leaving aware to get POA consent for send bed hold with resident the with resident taking leave an	om POA and ang resident copy. R6 and I and no seem to on. When the cumentation ed that this viewed and within facility. Edure on bedie educated, ations with at reside in pitals on a cleaves, all exidents being reviewed and nout. When g they are red bed hold, to hospital or	
	assessment dated	linimum Data Set (MDS) d 1/15/18, identified diagnoses pertension and weakness.		POA with note in resident charesidents were audited by dir nursing to ensure all had appropriate notification in place. No othe were affected. The Policy an	rector of propriate r residents	
	indicated R6 had evaluation of wea	tes on 2/1/18, at 9:42 a.m. note been admitted to the hospital for kness, fever and diarrhea.		for bed holds was reviewed of 3. To enhance currently control operations and under the director of nurses, on 4/24/20	on 4/17/2018 mpliant ection of the	
	bed hold informat	rd lacked documentation that ion was sent to the hospital for b's resident representative at the		will attended in-service training this policy and the importance holds. The training will empt	ng regarding e of bed	

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	PROVIDER OR SUPPLIER  G REHABILITATION 8	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		
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	time of transfers to contact the resident bed hold policy.  On 3/28/18, at 1:10 (LSW)-A confirmed residents' represent policy and indicate completed bed hold.  On 3/28/18, at 1:41 (DON) confirmed Fedocumentation of brown and make changes facility interdisciplinand would review than make changes.  The facility policy time to the facility member; asked any temporary transporary	the hospital, or attempts to the representative to offer the policies.  p.m. licensed social worker ashe did not notify residents or tatives of the facility bed hold the business office policies.  p.m. director of nursing policies policies.  p.m. director of nursing policies.  p.m. director	F 636	must be done with all residents bei out of facility going out on leave or transferring to hospital.  4. Effective 4/17/2018, a quality-assurance program was implemented under the supervisior SW in conjunction with DON to mo any transfers to ensure appropriate notification given. The SW or designated will complete 2 audits per week x 4 on residents that have transferred then 1 audit weekly for 4 weeks en staff comply with current policy. An deficiencies will be corrected on the and the findings of the quality-assurance committee meeting for further revision corrective action.  5. SW will be responsible for this	n of the onitor egnee weeks or left, sure ye spot, irance bmitted	5/4/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER  G REHABILITATION	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP ( 907 MARSHALL AVENUE, PO BOX HENNING, MN 56551	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
F 636	goals, life history a resident assessm by CMS. The ass the following: (i) Identification ar (ii) Customary rou (iii) Cognitive patte (iv) Communication (v) Vision. (vi) Mood and behavior (vii) Psychological (viii) Physical function (ix) Continence. (x) Disease diagnomatical (xii) Dental and nutomatical (xiii) Activity pursu (xiv) Medications. (xv) Special treatromatical (xviii) Documentatomatical (xviiii) Documentatomatical (xviiii) Documentatomatical (xviiii) Documentatomatical (xviiii) Documentatomatical (xviiii) Documentatomatical (xviiii) Documentatomatical (xviiiii) Documentatomatical (xviiiiii) Documentatomatical (xviiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	and preferences, using the ent instrument (RAI) specified essment must include at least and demographic information tine.  erns.  ertitional status.  erns.  erns.	F6	536		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER  REHABILITATION	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 636	apply to CAHs.  (i) Within 14 calen excluding readmis significant change mental condition. ("readmission" mea following a tempor or therapeutic leav (iii)Not less than o This REQUIREME by: Based on intervier facility failed to ense Assessments (CA analysis of a resid history and prefere R14,R15, R124) reference R14,R15, R124) reference R9 R9's significant change include:  R9 R9's significant change include: R9 R9's Care Area As 5/23/17, identified from the data enterence include:	dar days after admission, sions in which there is no in the resident's physical or (For purposes of this section, ans a return to the facility cary absence for hospitalization (e.) Ince every 12 months. ENT is not met as evidenced where and document review the sure resident Care Area (A) included a comprehensive ent's needs, strengths, goals, ences for 4 of 5 residents (R9, eviewed.  In ange Minimum Data Set (17, identified severe cognitive agnoses which included er (bladder dysfunction) ciety. The MDS indicated R9 on with transfer, ambulation equired extensive assistance personal hygiene, The MDS behaviors not directed at others during the assessment period depressant and diuretic antibiotics five days and	F 636	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submis of this Plan of Correction is not an admission that a deficiency exists o one was cited correctly. This Plan of Correction is submitted to meet requirements established by state a federal law.  1. It is the policy of this facility to e all residents are assessed correctly assessments and MDS to coordinat appropriate care plans. Some of the many ways that this has been achie for R9, R14, R15, and R124 is by reviewing each of the triggered care and since the areas lacked comprehensive analysis as to why t areas triggered, each care area was reviewed and corrected to ensure adequate assessments were compl to gather data based on direct obse and communication with resident ar on all shifts. The MDS nurse was instructed per the RAI manual to ide and use tolls that are grounded in colinical standardsto gather data the necessary in completing the CAA presents.	the ssion  r that of  nd  nsure via  se  eved  e areas  he  s  eted  rvation  nd staff  entify  urrent  nat is

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F 636	Continued From pa	ge 15	F 6	36			
	Cognitive Loss/Den Functional/Rehabili Incontinence and In Symptoms, Falls, Nulcer and Psychotro-Cognitive Loss/De area was an actual indicate why. The Copre-populated checentered on the MDS Neurological factors mood and behavior functional status an requiring additional cognition. The CAA analysis of the aforecheckmarks which functioning. The CAC considerations that functioning from rescommunication with staff members and care planning consistency. The CAA reverse check marked area and conditions, memor the communication. The comprehensive ana pre-populated checent communication. The communication in the communication. The communication is the communication of the communication. The comprehensive ana pre-populated checent communication. The other consideration	mentia, Communication, ADL tation Potential, Urinary indwelling Catheter, Behavioral lutritional Status, Pressure opic Drug Use.  mentia CAA revealed the care problem for R9, but did not CAA revealed multiple is marked areas (from data S), which included: so, observable characteristics, medical problems, pain, and other considerations, assessment/analysis of R9's alacked a comprehensive ementioned pre-populated impacted R9's cognitive in licensed and non-licensed resident and/or family input for iderations.  AA revealed the care area was for R9, but did not indicate aled multiple pre-populated is, which included: diseases dications and characteristics on impairment which required ent/analysis of R9's			In this case, after the surveyor reporesidents listed above had care are assessments that were inaccurate incomplete based on documentation MDS; all care plans have been reviand updated, MDS nurse has complianted to properly document on CAA's.  2. Because all residents are assed termine their appropriate plan of based on their assessments all are potentially affected by the cited defion 4/17/2018, the MDS nurse revie accuracy of CAA's and MDS that surveyors noted to be inaccurate. A resident CAA's will be reviewed for timeliness and accuracy. Furthermode CAA's being created as of 4/17/2016 be double checked by regional reimbursement coordinator prior to submission to ensure compliance. on MDS/CAA was reviewed. No oth residents were affected.  3. To enhance currently compliant operations and under the direction director of nurses, on 4/24/2018 all received in-service training regarding state and federal requirements for documentation, assessments and processed to the MDS nurse to fol on items that are not being addressed during assessment period and ensure care areas are complete.  4. Effective 4/17/2018, a quality-assurance program was	a or n and ewed obleted f how ssed to care ciency, wed all other ore, all 8 will Policy per to staffing proper to s. The low up sed	

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F 636	staff members and care planning considerations that functioning. The Capanalysis of the aforcheckmarks which functioning. The Considerations that functioning from recommunication wistaff members and care planning considerated the problem for R9, but CAA revealed the problem for R9, but CAA revealed multimarked areas which contributing to R9 diseases and conditioned problem for R9, but CAA revealed multimarked areas which impact CAA lacked a compare as which impact CAA further lacked could affect R9's conditioned problem for CAA further lacked could affect R9's consideration, common-licensed staff input for care planting to R9 diseases and conditions and consideration of the could affect R9's consideration.	d resident and/or family input for siderations.  The habilitation Potential CAA area was an actual problem for icate why. The CAA revealed ated check marked areas, sible underlying problems ction, medications and at risk for because of functional lacked ADL problem evaluation, is and a comprehensive rementioned pre-populated impacted R9's ADL AA further lacked any other it could affect R9's ADL esident observation, the licensed and non-licensed diresident and/or family input for	F	536	MDS nurse to that all residents will reviewed at time of admission or ar ensure CAA's are being completed thoroughly and completely. All trigg be care planned and communicate staff via care sheets and communic book if new interventions in place. A of CAA's will be completed for accuand timeliness; they will be comple MDS nurse 2 audits per week x 4 withen 1 audit weekly x 2 months to ecompliance in this area. Any deficie will be corrected on the spot, and the findings of the quality-assurance characteristic meeting for further review or corrected action.  5. MDS nurse will be responsible POC.	ers will d to cation Audits uracy ted by veeks encies ne necks at the eective	

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F 636	indicate why. The opre-populated cherincluded: cognitive cause or exacerbal lacked a comprehe aforementioned prareas which impact further lacked any affect R9's behavious communication with staff and resident aplanning consideration.  Falls CAA revealed problem for R9, but CAA revealed multimarked areas which performance limitarisk factors. The Canalysis of the aforcheck marked arearisk. The CAA furth considerations that is from resident with licensed and rand/or family input considerations.	CAA revealed multiple ck marked areas which status problems that can te R9's behavior. The CAA ensive analysis of the e-populated check marked eted R9's behavior. The CAA other considerations that could be from resident observation, the licensed and non-licensed end/or family input for care entions.  If the care area was a potential of the care populated check of the check of the care populated as which impacted R9's fall observation, communication non-licensed staff and resident for care planning	F 63	36		
	was a an actual prindicate why. The operation of the included: R9's fund behavioral problem medications. The operation of the aforecheck marked area nutritional risk. The	CAA revealed the care area oblem for R9, but did not CAA revealed multiple ck marked areas which ctional and mental status, as, disease conditions and CAA lacked a comprehensive rementioned pre-populated as which impacted R9's c CAA further lacked any other t could have affected R9's				

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F 636	nutritional risk from communication with staff and resident a planning considera -Pressure Ulcer CA a potential problem why. The CAA rever check marked area external risk factors that present complifor pressure ulcers comprehensive and pre-populated check impacted R9's risk further lacked any have affected R9's resident observation licensed and non-licensed and anti-psychotropic Drugarea was an actual indicate why. The Copre-populated check included: classes of treatable reasons from adverse consecution and adverse consecution and anti-psychotic comprehensive and pre-populated check impacted R9's risk medications. The Considerations that	resident observation, in licensed and non-licensed and/or family input for care area was for R9, but did not indicate alled multiple pre-populated as which included: internal and and/or medications and conditions and conditions or increase R9's risk. The CAA lacked a allysis of the aforementioned and was allowed areas which of pressure ulcers. The CAA and ther considerations that could risk of pressure ulcers from and and and resident for care planning.  Use CAA revealed the care problem for R9, but did not CAA revealed multiple and marked areas which and federation R9 was taking, or use of psychotropic drug quences of anti-depressant medication. The CAA lacked a allysis of the aforementioned and was affected any other could have affected R9's risk	F 6	36			
	impacted R9's risk medications. The C considerations that of using psychotrop observation, comm	of using psychotropic CAA further lacked any other could have affected R9's risk pic medications from resident unication with licensed and and resident and/or family input					

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F 636	R14 R14's Annual Mini 8/31/17, identified impairment, had d Cerebral Palsy and (GERD). The MDS extensive assistant dressing and hygicatoileting and transitation and natural tee. R14's Care Area A 8/31/17, identified from the data enternallysis. The follo Cognitive Loss/De Communication, Undwelling Cathetes Dental Care, Presently Use.  -Cognitive Loss/De area was an actual cognitive loss and CAA revealed mulmarked areas (frowhich included: obtained behavior, medicational assessing cognition. The CA analysis of the aforcheckmarks which functioning. The Considerations that functioning from recommunication with the communication with the c	mum Data Set (MDS) dated R14 had sever cognitive iagnoses which included d gastric esophageal reflux identified R14 required nice for bed mobility, locomotion, ene, total assistance with fer, supervision with eating and	F 630		

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F 636	care planning cons  -Visual Function CA an actual problem f why. The CAA reve check marked area MDS), which includ medications, requir assessment/analys lacked a comprehe aforementioned pre impacted R14's visi lacked any other co R14's cognitive fun observation, comm non-licensed staff r family input for care  -Communication CA an actual problem f why. The CAA reve check marked area and conditions, me of the communicati additional assessm communication. Th comprehensive and pre-populated chec communication fror communication with staff members and care planning cons  -Urinary Incontinen CAA revealed the co problem for R14, di	AA revealed the care area was for R14, but did not indicate saled multiple pre-populated as (from data entered on the led: disease conditions, and ing additional as of R14's cognition. The CAA ansive analysis of the e-populated checkmarks which used function. The CAA further considerations that could affect ctioning from resident unication with licensed and members and resident and/or e planning considerations.  AA revealed the care area was for R14, but did not indicate as which included: diseases dications and characteristics on impairment which required tent/analysis of R9's e CAA lacked a salysis of the aforementioned skmarks which impacted R14's e CAA further lacked any st that could affect R14's m resident observation, in licensed and non-licensed resident and/or family input for	F6	36			

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F 636	toileting The CAA pre-populated check included: modifiable urinary incontinence medications. The Canalysis of the afor check marked area incontinence. The Considerations that from resident obselicensed and non-lideration for family input for considerations. The CAA revealed multimarked areas which performance limitarisk factors. The CA analysis of the afor check marked area risk. The CAA furth considerations that risk from resident cowith licensed and mand/or family input considerations.	revealed multiple ck marked areas which e factors contributing to R14's e, diseases and conditions and CAA lacked a comprehensive ementioned pre-populated as which impacted R14's CAA further lacked any other could affect R14's continence rvation, communication with censed staff and resident and care planning considerations.  If the care area was a potential ut did not indicate why. The iple pre-populated check th included: R14's physical tions, medications and internal AA lacked a comprehensive ementioned pre-populated as which impacted R14's fall er lacked any other could have affected R14's fall observation, communication ion-licensed staff and resident	F6	36			
	was a an actual pro- indicate why. The C pre-populated chec- included: R14's fun- behavioral problem conditions and med comprehensive and pre-populated chec- impacted R14's nut	beloblem for R14, but did not CAA revealed multiple ck marked areas which actional and mental status, as, communication, disease dications. The CAA lacked a alysis of the aforementioned ck marked areas which tritional risk. The CAA further considerations that could have					

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F 636	affected R14's nutrobservation, common-licensed staff afor care planning co-Dental Care CAA an actual problem natural teeth, has used that he will wear as revealed multiple pareas which include functional problem medications. The Canalysis of the afor check marked arearisk. The CAA furth considerations that dental risk from rescommunication with staff and resident aplanning considerations. The CAA reverse apotential problem why. The CAA reverse was a potential problem why. The CAA reverse check marked area external risk factor that present complete for pressure ulcers comprehensive and pre-populated check impacted R14's ris further lacked any have affected R14' resident observation.	ritional risk from resident nunication with licensed and and resident and/or family input onsiderations.  revealed the care area was a for R14, due to R14 has no upper and lower full dentures the chooses. The CAA ore-populated check marked ed: R14's cognitive and as and disease conditions and CAA lacked a comprehensive rementioned pre-populated as which impacted R14's dental per lacked any other the could have affected R14's sident observation, the licensed and non-licensed and/or family input for care used and/or family input for care ealed multiple pre-populated as which included: internal and and so, medications and conditions ications or increase R14's risk and the CAA lacked a subject of the aforementioned continuous of the aforementioned continuous of the aforementioned continuous ications or increase R14's risk and the considerations that could as risk of pressure ulcers. The CAA other considerations with censed staff and resident	F 63	6			

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F 636	-Psychotropic Drug area was an actual indicate why. The C pre-populated checincluded: classes of treatable reasons from and adverse conseand anti-psychotic recomprehensive and pre-populated checimpacted R14's risk medications. The C considerations that of using psychotropobservation, common-licensed staff of care planning compacted R14's CAAs. MDSC R14's CAAs. MDSC	Use CAA revealed the care problem for R14, but did not CAA revealed multiple of the marked areas which of medication R14 was taking, or use of psychotropic drug quences of anti-depressant medication. The CAA lacked a alysis of the aforementioned of the marked areas which of using psychotropic caAA further lacked any other could have affected R14's risk bic medications from resident unication with licensed and and resident and/or family input onsiderations.  p.m. MDS coordinator she had completed R9 and C-A verified the CAAs lacked populated data and were not a	F6	36			

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F 636	Continued From p	age 24	F6	36				
	6/19/17, identified cognition, and diagrarkinson's disease. The MDS identifies activities of daily lift for transfers, walk extensive assistant dressing, toileting MDS indicated R1 behavioral symptowandered on 1-3 operiod. The MDS	Minimum Data Set (MDS) dated R15 had moderately impaired gnoses which included se, dementia and depression. d R15 required assistance with ving (ADL) such as, supervision ing and eating, and required nee from staff for bed mobility, and personal hygiene. The 5 had hallucinations, other oms not directed at others and days of the 7 day assessment further identified R15 received a c medication and a daily edication.						
	6/29/17, identified from the data ente analysis, the follow Cognitive Loss/De Functional/Rehabi Incontinence and	Assessments (CAA) dated eight care areas had triggered ered into the MDS requiring ving care areas were triggered: ementia, Communication, ADL litation Potential, Urinary Indwelling Catheter, Behavioral Pressure Ulcer and						
	area was an actual diagnosis of deme multiple pre-popul data entered on the neurological factor	ementia CAA revealed the care al problem for R15, related to a entia. The CAA revealed ated check marked areas (from the MDS), which included: rs and ADL function, requiring ment/analysis of R15's						

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F 636	cognition. The CA analysis of the afor checkmarks which functioning. The Considerations that functioning from recommunication wistaff members and care planning con-Communication of an actual problem why. The CAA reverse communications, most the communication. To comprehensive arroppulated checkmarked areas and conditional assessing communication. To ther consideration communication from the communication wistaff members and care planning con-ADL Functional/Frevealed the care R15 related to dia and dementia. The toperform ADLs in other times R15 recalled multiple can be communicated areas, who problems affecting and problems R15 functional decline.	A lacked a comprehensive rementioned pre-populated impacted R15's cognitive AA further lacked any other at could affect R15's cognitive esident observation, th licensed and non-licensed diresident and/or family input for siderations.  CAA revealed the care area was for R15, but did not indicate ealed multiple pre-populated as, which included: diseases edications and characteristics tion impairment which required ment/analysis of R15's he CAA lacked a nalysis of the aforementioned ackmarks which impacted R15's he CAA further lacked any in that could affect R15's or resident observation, th licensed and non-licensed diresident and/or family input for	F 636				

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F 636	comprehensive ar pre-populated che ADL functioning. To other consideration functioning from recommunication wistaff members and care planning con -Urinary Incontine CAA revealed the problem for R15, I CAA revealed mulmarked areas whi contributing to R1 diseases and conditionate CAA further lacked a compareas which impared CAA further lacked could affect R15's observation, common-licensed staff input for care planded and the pre-populated che included: nature of conditions that can factors that can can behavior. The CAA analysis of the affect check marked are behavior. The CAA considerations that from resident observation of the form resident observatio	nalysis of the aforementioned ockmarks which impacted R15's The CAA further lacked any ns that could affect R15's ADL esident observation, th licensed and non-licensed d resident and/or family input for	F 636				

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	PROVIDER OR SUPPLIER  G REHABILITATION 8	HEALTHCARE CENTER		9	TREET ADDRESS, CITY, STATE, ZIP CODE 07 MARSHALL AVENUE, PO BOX 57 IENNING, MN 56551	,	
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F 636	and/or family input considerations.  -Falls CAA revealed problem for R15, b CAA revealed mult marked areas whice performance limitar risk factors. The Canalysis of the afore check marked areas risk. The CAA furth considerations that risk from resident of with licensed and read and/or family input considerations.  -Pressure Ulcer CA a potential problem why. The CAA revealed marked areas external risk factors that present complifor pressure ulcers comprehensive and pre-populated check impacted R15's risi further lacked any have affected R15' resident observation licensed and non-licensed and non-	d the care area was a potential ut did not indicate why. The iple pre-populated check the included: R15's physical tions, medications and internal AA lacked a comprehensive ementioned pre-populated as which impacted R15's fall er lacked any other could have affected R15's fall observation, communication ion-licensed staff and resident for care planning  AA revealed the care area was a for R15, but did not indicate ealed multiple pre-populated as which included: internal and as, medications and conditions ications or increase R15's risk. The CAA lacked a alysis of the aforementioned as k marked areas which is of pressure ulcers. The CAA other considerations that could as risk of pressure ulcers from ion, communication with censed staff and resident for care planning	F6	36			
	indicate why. The 0	problem for R15, but did not CAA revealed multiple ck marked areas which					

· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245540	B. WING		03/	29/2018
	PROVIDER OR SUPPLIER  G REHABILITATION	& HEALTHCARE CENTER	9	STREET ADDRESS, CITY, STATE, ZIP CODE 207 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPRIES OF THE APPROPRIES OF T	D BE	(X5) COMPLETION DATE
F 636	included: classes treatable reasons and adverse consumant anti-psychotic comprehensive ar pre-populated che impacted R15's rismedications. The considerations that of using psychotropservation, common-licensed staff for care planning of Con 3/29/18, at 3:5 (MDSC)-A confirm dated 6/29/17. MD lacked analysis of MDS and had no formal consumers of the consumers of t	of medication R15 was taking, for use of psychotropic drug equences of anti-depressant medication. The CAA lacked a nalysis of the aforementioned ock marked areas which sk of using psychotropic CAA further lacked any other at could have affected R15's risk opic medications from resident munication with licensed and and resident and/or family input considerations.  5 p.m. MDS coordinator need she completed R15's CAAs pSC-A stated R15's CAAs pre-populated data from R15's further considerations which care areas and therefore were	F 636			
	diagnoses which in cancer, arthritis are pulmonary disease identified R124 was required extensive transfers, hygiene frequent urinary in bowel incontinence R124 had no natu	DS, dated 6/29/17, identified included; diabetes mellitus, and chronic obstructive in (COPD). R124's MDS further is cognitively intact and it is assistance with bed mobility, and toilet use. R124 had continence and occasional in item. The MDS also identified ral teeth, had fallen since last was at risk for pressure ulcers.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245540	B. WING			03/2	29/2018
	PROVIDER OR SUPPLIER  G REHABILITATION 8	HEALTHCARE CENTER		907	REET ADDRESS, CITY, STATE, ZIP CODE  MARSHALL AVENUE, PO BOX 57  NNING, MN 56551		
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F 636	areas triggered from MDS requiring analytriggered; ADL Functional St. Pressure Ulcer.  -ADL Functional/Reservealed the care at R124. The CAA ide extensive assistant locomotion, dressin hygiene. The CAA ide extensive assistant locomotion, dressin hygiene. The CAA in pre-populated check included possible ut R124's functional declinoproblem evaluation comprehensive and pre-populated check R124's ADL functionany other considers ADL functioning from communication with staff members and care planning consumary Incontinent CAA revealed multimarked areas whice contributing to R12 diseases and condicated a compaforementioned present in the problem for R124, Incontributing to R12 diseases and condicated a compaforementioned present in the problem for R124, Incontributing to R12 diseases and condicated a compaforementioned present in the problem for R124 in R124 diseases and condicated a compaforementioned present in R124 in R124 diseases and condicated a compaforementioned present in R124 in R124 diseases and condicated a compaforementioned present in R124 disease	d 7/2/17, identified six care in the data entered into the lysis, the following areas were ctional/Rehabilitation Potential, and Indwelling Catheter, atus, Dental Care and enabilitation Potential CAA area was an actual problem for entified R124 required to with bed mobility, transfers, ag toilet use and personal revealed multiple is marked areas, which inderlying problems affecting diproblems. R124 was at risk endered and a lysis of the aforementioned is kmarks which impacted in the CAA further lacked ations that could affect R124's im resident observation, in licensed and non-licensed resident and/or family input for	F 6	36			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  G REHABILITATION 8	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP ( 907 MARSHALL AVENUE, PO BOX HENNING, MN 56551	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 636	CAA further lacked could affect R124's observation, common-licensed staff input for care plant -Falls CAA reveale problem for R124, CAA revealed mult marked areas which performance limitarisk factors. The Canalysis of the afor check marked arearisk. The CAA furth considerations that fall risk from reside	age 30 I any other considerations that is continence from resident nunication with licensed and and resident and /or family ning considerations.  I d the care area was an actual but did not indicate why. The iple pre-populated check in included: R124's physical tions, medications and internal AA lacked a comprehensive rementioned pre-populated as which impacted R124's fall her lacked any other it could have affected R124's ent observation, communication non-licensed staff and resident	F 63			
	was an actual probindicate why. The pre-populated checincluded; R124's further problems, other dismedications. The analysis of the afor check marked arearisk. The CAA furth considerations that fall risk from reside with licensed and rand/or family input considerations.  -Dental Care CAA	CAA revealed the care area plem for R124, but did not CAA revealed multiple ck marked areas which unctional problems, cognitive seases and conditions and CAA lacked a comprehensive rementioned pre-populated as which impacted R124's fall per lacked any other a could have affected R124's ent observation, communication non-licensed staff and resident				

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	PROVIDER OR SUPPLIER  G REHABILITATION 8	& HEALTHCARE CENTER		90	TREET ADDRESS, CITY, STATE, ZIP CODE D7 MARSHALL AVENUE, PO BOX 57 ENNING, MN 56551		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 636	why. The CAA reversible cognitive problems medications, disea lacked a compreher aforementioned progress which impact further lacked any have affected R124 observation, common-licensed staff of care planning of the CAA reversible. The CAA reversible comprehensive and pre-populated check marked area external risk factors that present complimited R124's richard for pressure ulcomprehensive and pre-populated check impacted R124's richard for family input considerations.  On 3/29/18, at 3:41 R124's CAAs were indicated she had dindicated she was lacked a comprehensive and pre-populated check indicated she was lacked a comprehensive and pre-populated checked and resident and/or family input considerations.	ealed multiple pre-populated as which included: R124's , functional impairment, ses and conditions. The CAA ensive analysis of the e-populated check marked ted R124's fall risk. The CAA other considerations that could 4's fall risk from resident nunication with licensed and and resident and/or family input onsiderations.  AA revealed the care area was a for R124, but did not indicate ealed multiple pre-populated as which included: internal and as, medications and conditions ications or increase R124's cers. The CAA lacked a alysis of the aforementioned ck marked areas which sk of pressure ulcers. The any other considerations that d R124's risk of pressure it observation, communication non-licensed staff and resident	F 6	336			

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	PROVIDER OR SUPPLIER  G REHABILITATION 8	HEALTHCARE CENTER		90	REET ADDRESS, CITY, STATE, ZIP CODE 17 MARSHALL AVENUE, PO BOX 57 ENNING, MN 56551		
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F 636	all resident's CAAs recently been informanother facility she on contacting the fadetermine why her saved.  On 3/29/18, at 4:00 CAAs lacked a concontained re-popul DON indicated her and summaries to  The facility policy ti 3/22/18, indicated to completion of the Copolicy instructed stafor each triggered decision-making prodecision, a focused causal factors, profactors. The CAAs Assessment/Analydesignated date.  RAI manual dated were triggered by to that indicate the nebased on problem "triggered care are between the MDS aplanning. The RAI process provides good key issues identified manual identified wactual or potential protential	inge 32  . MDSC-A indicated she had med this had happened at was working at, and planned acility consultant to help documentation had not been  I p.m. DON confirmed R124's inprehensive analysis, and only ated check marked areas. expectation would be for notes be included in the CAAs.  Itled MDS/CAA Policy, dated the MDS nurse will monitor the CAA summary sections. The aff to complete documentation condition including clinical rocess. In the documented distatement will include key blems, complications and risk summary and the CAA sis to be completed by the  10/17, identified Care Areas he MDS items in responses red for additional assessment identification, known as as," which form a critical link and decisions about care manual identified the CAA uidance on how to focus on diduring a comprehensive and directed facility staff to care areas. Further the RAI whereas the MDS identified problems, the CAA process assessment of the triggered	F6	336			

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F 636	areas by guiding siconfounding factor documentation inc factors for decline addition the RAI minstructed to identicurrent and ground of practice and who of sound clinical promaking skills were CAA process. Discharge Summa CFR(s): 483.21(c)(2) Discounded the facility amust have a dischabut is not limited to (i) A recapitulation includes, but is not of illness/treatmentatiology, and considiously	aff to look for causal or s and was important the CAA luded the causal or unique risk or lack of improvement. In anual indicated facilities were fy and use tools that were ded in current clinical standards en applied to practice, the use oblem solving and decision imperative in completing the ry (2)(i)-(iv)  harge Summary enticipates discharge, a resident arge summary that includes, of the resident's stay that limited to, diagnoses, course to the rapy, and pertinent lab, sultation results. Yof the resident's status to ragraph (b)(1) of §483.20, at charge that is available for ed persons and agencies, with resident or resident's	F 63			5/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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HENNIN	G REHABILITATION	& HEALTHCARE CENTER		907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		
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F 661	the individual plan	page 34 ns to reside, any arrangements ade for the resident's follow up	F 66	1		
	non-medical servi This REQUIREMI by:	ENT is not met as evidenced				
	facility failed to er summary for 1 of	ew and document review, the asure an accurate discharge 1 resident (R24) who was ne from the facility.		This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submit of this Plan of Correction is not an admission that a deficiency exists of the constitution of th	the ission	
	Findings include:			one was cited correctly. This Plan Correction is submitted to meet		
	indicated R24 wa 12/13/17, with dia	mission Record dated 1/4/18, as admitted to the facility on gnoses which included ates and hypoxemia.		requirements established by state federal law.  1. It is the policy of this facility to all residents who discharge from facility all the information and tools to	ensure acility	
	Review of R24's Physician Discharge Summary (PDS) listed R24's name, attending physician, R24's medical record number, the date of admission 12/13/17, and the date of discharge 1/12/18 at 12:45 p.m. The remainder of the discharge summary was not completed, left			need to discharge successfully. The would include but not limited to: medication list, medical and nonmore appointments and treatments and recapitulation of resident stay. R24 discharged home without appropria	edical was	
	in nursing facility, information, signa above information	diagnosis, summary of course condition upon discharge, other sture of person completing n, date, prognosis (include		discharge plan. When the surveyor reported lack of documentation, it noted that the practice of discharge planning needed to start sooner are	was e	
	immediate care, of signature of atten summary form lad	ential), physician orders for discharge diagnosis and ding physician. In addition, the cked documentation of 824's medications sent home,		complete for all residents upon discharging, this practice had not be followed per policy and best practice Immediately policy and procedure discharge planning was reviewed a	ce. on	
	Review of R24's F 1/12/18 revealed	Progress Notes from 1/4/18 to the following:		would initiate discharge planning p resident discharge.  2. Because many residents that of facility do so for short stays many a	rior to come to are	
		vices (SS) met with R24 and bout discharging, plan to		potentially affected by the cited def Immediately all residents being	iciency.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION  G		E SURVEY PLETED
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0(4) ID	CLIMMADV C	TATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRE	CTION	()(5)
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F 661	discharge on 1/18	1/18 due to significant other	F 66	discharged were reviewed and		
	having the day off. Discussed steps to enter home and lack of handrail at entrance. SS faxed medical doctor and he signed a referral for home health services (HHS).			plan in place and sent with res ensure successful discharge. I are alerted a resident is discha planning should start immedia therapy and then nursing to ge	When staff orging the ely with	
	staff felt R24 was Husband indicated	ovided education to husband not quite ready to go home. d R24 wanted to go home and		treatments, medications, adap equipment in check, along with level of ADL functioning. Disch	tive current arging	
	he was going to take her home. R24 indicated she was feeling better now, had agreed to go s her primary medical doctor on 2/8/18, and information given to husband. Medications sent			residents were audited by SW all had appropriate discharge place. No other residents were The Policy and Procedure for	olan in affected. discharge	
	aware. Skin upon red skin folds with	cy notified, medical director discharge, psoriasis patches, powders applied. Discharged ill medications and personal		planning was reviewed on 4/17 3. To enhance currently comperations and under the director of nurses, on 4/24/201	oliant tion of the	
	belongings with sp	oouse.		attended in-service training requestion policy and the importance of d	garding this scharge	
	R24 received con	ot been completed to ensure tinuous and coordinated,		planning. The training will emplement be done with all residents	3	
	summary did not i	care following discharge. The indicate if R24 was going to vices after discharge or if they		discharging to ensure the resident information, tools and resource discharge successfully.		
	assist R24 in her	ensure HHS would be able to home. The summary did not nation from physical and		<ol> <li>Effective 4/17/2018, a quality-assurance program wa implemented under the superv</li> </ol>		
	occupational thera	apy, did not include information ions or what those medications		SW in conjunction with DON to any discharges to ensure appr	monitor opriate	
	were or if R24 kne supposed to be ta	ew what medications she was lking.		planning was completed. The designee will complete 2 audit x 4 weeks on residents that ha	s per week	
	nursing (ADON) s	4 p.m. assistant director of tated she felt the director of the not know she was supposed to		transferred or left, then 1 audit 4 weeks ensure staff comply w policy. Any deficiencies will be	weekly for vith current	
	be completing dis not being done. T	charge summaries and were he ADON indicated she felt R24 me health services for therapy		on the spot, and the findings o quality-assurance checks will be documented and submitted at	f the be	
		charge and SS worked with		quality-assurance committee r	•	

1, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  G REHABILITATION 8	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP C 907 MARSHALL AVENUE, PO BOX HENNING, MN 56551	CODE		
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F 661	indicated SS usuall they were discharge doing at home. ADO summaries were to resident was discharge summaries of the completed when facility. The DON in include discharge of medications, pharm equipment needed she just got a pile of week that went backindicated the facility person recently and	age 36 Is up for the resident. She by called the residents once and to check how they were on indicated the discharge of the completed after any arged from the facility.  In p.m. DON confirmed a by including a recapitulation was in R24 discharged from the indicated the summary should orders, home health if needed, in acy resident wanted and at home. The DON indicated of discharges on her desk last the several months. The DON by had a new medical records it is a summaries.	F 60	further review or corrective 5. SW will be responsible			
	Resident dated 12/to ensure the resided discharge to the net doctors order, list of and any special insupplysician services. Ensure residents having place to offer a condition of the condition	ng (ADLs)/Mntn Abilities	F 6	76		5/4/18	

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F 676	of the individual's that such diminution includes the facilities \$483.24(a)(1) A retreatment and ser or her ability to calliving, including the of this section  §483.24(b) Activities The facility must pactordance with pactivities of daily lies \$483.24(b)(1) Hyggrooming, and orange \$483.24(b)(2) Molincluding walking, \$483.24(b)(3) Elines \$483.24(b)(4) Diminus \$483.24(b)(5) Cor(i) Speech, (ii) Language, (iii) Other function This REQUIREMED by:  Based on observatives to maintal	clinical condition demonstrate on was unavoidable. This y ensuring that:  esident is given the appropriate vices to maintain or improve his rry out the activities of daily ose specified in paragraph (b)  es of daily living.  erovide care and services in aragraph (a) for the following ving:  liene -bathing, dressing, all care,  bility-transfer and ambulation,	F 6	This Plan of Correction cons written allegation of complian deficiencies cited. However, sof this Plan of Correction is not admission that a deficiency e one was cited correctly. This Correction is submitted to me	ce for the submission ot an xists or that Plan of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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HENNING	G REHABILITATION	& HEALTHCARE CENTER		907 MARSHALL AVENUE, PO BOX 8 HENNING, MN 56551	) <i>(</i>		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5)	
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)		COMPLETION DATE	
F 676	Continued From p	page 38	F 67	6			
				requirements established by	state and		
		linimum Data Set (MDS) dated		federal law.			
		R14 had severe cognitive		It is the policy of this fact			
		ad diagnoses which included		care and services for activition			
		iabetes Mellitus and gastric		living. Some of the many wa			
		(GERD). The MDS identified al teeth, and required extensive		has been achieved for R14 i resident with his dentures ar			
		d mobility, locomotion, personal		cares in morning and evening			
		sing, total assistance for transfer		case, after the surveyor dete			
	and toilet use.	onig, total accionance for transfer		was not offered any oral care			
				with placing dentures, imme			
	R14's Care Area	Assessment (CAA) dated		were reminded the importan			
	8/31/17, identified	R14 cognitive loss, mental		assisting residents with all as	spects of the		
		had no natural teeth, had full		ADL's including oral care. Ca			
		lentures that he wears as he		were updated to include resi			
		es with dentures, no mouth		need assistance with oral ca	re and those		
		assist as needed. The CAA		that have dentures.	- 4- 1		
		stable diabetes related to oral		2. Because all residents ar			
		overall objective was to maintain nctioning, avoid complications		good oral care all are potent by the cited deficiency, on 4/			
	and minimize risk	• •		DON and ADON reviewed a			
	and minimize non	<b>5.</b>		ensure all are receiving prop			
	R14's care plan re	evised 9/5/17, identified R14		Other residents determined			
		ce with activities of daily living		dentures were identified and			
		interventions which included		denture placement. Policy ar	nd procedure		
	set up of oral care	e supplies, encourage and assist		on ADL's has been reviewed	l. No other		
		ice a day and as needed.		residents were affected.			
		plan listed to encourage R14 to		3. To enhance currently co			
		se fixodent for fit, and would		operations and under the dir			
	often refuse to we	ear dentures.		director of nurses, on 4/24/2			
	On 3/28/19 at 7:0	00 a m. nursing assistant (NA) A		received in-service training r			
		00 a.m. nursing assistant (NA)-A ed R14 with morning cares.		assistance with ADL's. The emphasize the importance of			
		basin of water in the adjoining		ADL's listed on care sheets			
		A-A applied R14's stockings		that care to dependent resid			
		sweat pants on R14's lower legs.		4. Effective 4/17/2018, a			
		vorked together to wash and		quality-assurance program v	vas		
		ad no natural teeth, his mouth		implemented under the supe			
		ken appearance with his mouth		DON and ADON to monitor i			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245540	B. WING _		03/2	29/2018	
	PROVIDER OR SUPPLIER  G REHABILITATION	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZII 907 MARSHALL AVENUE, PO BO HENNING, MN 56551	PCODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 676	closed. At 7:14 a.r on a sling with a fu wheel chair. NA-D wash and dry his fi combed his hair, wash and dry his fi combed his hair, wash and dry his fi combed his hair, wash and confirmed the separate opaque in NA-D exited the rown NA-D exited the rown or not a stated they morning cares and breakfast later.  On 3/29/18, at 1:1 had not assisted if and confirmed she R14's mouth nor indentures. NA-D in practice was to profor dependent result not usually offer in not wear them at the confirmed his determined the usual facility pwith oral cares. Nor R14 had dentures with dentures.  On 3/29/18, at 2:3 (DON) verified R1 the nursing assistant assessment. The staff to assist with evening, including to be offered to sweet as the confirmed to sweet as the confirmed to sweet as the confirmed she confirmed she confirmed to sweet as the confirmed she confirmed she confirmed to sweet as the confirmed she co	m. R14 was lifted from the bed all body lift and seated in his a continued to assist R14 to face, neck, glasses and while NA-A made R14's bed. A-A completed R14's cares, soiled linens and garbage into plastic bags, and NA-A and bom. At 7:21 a.m. NA-D and had finished providing R14's did he would be assisted to assisted to assisted to assisted to assisted the usual facility by ovide assistance with oral cares idents. She indicated she did 14 his dentures because he did	F 67	dependent on staff for AD or designated quality-assisted representative will perform systematic audits of residnassistance with ADL's to completing cares per assistance plan by conducting 4 x 4 weeks then 2 audits performed and the systematic audits of the quarterly or annual to ensure complication of the spot, and the quality-assurance check documented and submitted quality-assurance commits further review or correctives. DON will be responsive to the systematic audits of the systematic aud	urance In the following Ients receiving Ients receiving Iensure staff are Iessment and Is audits per week Is audits per week Is area. It week x 2 Ience in this area. It weed at time of It is area in the iencies will be iencies		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION DING		ATE SURVEY OMPLETED
		245540	B. WING	i	0;	3/29/2018
	PROVIDER OR SUPPLIER  G REHABILITATION 8	HEALTHCARE CENTER	•	STREET ADDRESS, CITY, STATE, ZIP 907 MARSHALL AVENUE, PO BO HENNING, MN 56551	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	expected staff to of care plan directed.  The facility policy til 12/27/18, identified resident's lips and and freshen the resinfections of the monograph of th	fer R14 his dentures as the steed Mouth Care dated the purpose to keep the oral tissues moist, to cleanse sident's mouth, and to prevent outh. Intinence, Catheter, UTI 1)-(3)  Hence. If acility must ensure that stinent of bladder and bowel on services and assistance to e unless his or her clinical ones such that continence is ntain.  It resident with urinary don the resident's essment, the facility must ensure that is not catheterized unless the ondition demonstrates that encessary; enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary; is incontinent of bladder e treatment and services to st infections and to restore		690		5/4/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE COMP	SURVEY LETED
		245540	B. WING		03/2	9/2018
	PROVIDER OR SUPPLIER	& HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 690	Continued From possible. This REQUIREME by: Based on observareview, the facility with toileting for 1 toileting needs dur facility failed to profor 1 of 1 (R1) resi indwelling catheter Findings include: R9's significant che (MDS) dated 5/23/impairment and dianeurogenic bladded dementia, and anxiequired supervisicand required exter and personal hygier R9's care plan rev physical functionin	age 41 a resident with fecal ed on the resident's sessment, the facility must dent who is incontinent of bowel ite treatment and services to ormal bowel function as ENT is not met as evidenced ation, interview, and document failed to provide assistance of 1 resident (R9) observed for ring the survey. In addition the ovide appropriate catheter care dents reviewed with an  anage Minimum Data Set 17, identified severe cognitive agnoses which included er (bladder dysfunction) siety. The MDS indicated R9 on with transfer and ambulation asive assistance with toileting ene. ised 9/16/17, revealed a g deficit related to self care	F 690	This Plan of Correction constitutes written allegation of compliance for t deficiencies cited. However, submis of this Plan of Correction is not an admission that a deficiency exists or one was cited correctly. This Plan of Correction is submitted to meet requirements established by state at federal law.  1. It is the policy of the facility to princontinence care to all residents who need it based on bowel and bladder assessment and offer option of toiled program or continence program if reis able; as well as ensure proper car indwelling catheters. One of the mar ways that this has been achieved for resident #9 is to create a better toile program to keep resident dry by revisioned and bladder patterns, cognitive ability to cue or toilet and overall fundaments.	my the sion that f nd tovide no ting esident re of ny r ting iewing re ctional	
	needed). Staff to he resistive to care and dementia, become allow nursing staff incontinent. If residually living reassur 5-10 minutes later	ng assistance of 1 PRN (as all pelp change and wash. R9 is round toileting r/t (related to) es confused and refuses to to assist him when he is dent resists with activities of the resident, leave and return and try again. Provide resident for choice during care		ability. R1 has been monitored by not to confirm staff were aware of safe a proper catheter cares. After survey in the R9 was confused and consistent it was determined a new process new to be developed to prevent increase moisture to resident with potential impaired skin integrity and to meet be need to be clean and dry. R9 noted	and noted tly wet eded d	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G		E SURVEY PLETED	
		245540	B. WING		03/	29/2018	
	PROVIDER OR SUPPLIEF	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC 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 690	provision. R9 had intolerance, deme infection, physical use/side effects or Use of pull up disp the bathroom every perineal area with On 3/26/18, at 3:3 identified a concerproviding R9 with described an incicouting which result an hour with R9's During continuous following was obsent 6:51 a.m. R9 versult leather chair in the of the facility.  At 7:26 a.m. R9 real results and results are results are results and results are	bladder incontinence r/t activity ntia, HX (history) of urinary tract limitations, poor toileting habits, f medication antidepressants. cosable briefs. Offer to assist to ry two hours and PRN. Clean each incontinence episode.  8 p.m. family member (FM)-A rn that the facility staff were not timely toileting needs. FM-A lent when R9 was taken on an ted in a return to the facility in brief "soaking wet."  s observations on 3/28/18, the erved: was seated in a stationary brown e common area near the entry emained seated in the chair. Remained seated in the chair.	F 69	needing A1 with toileting and or schedule. The toileting program was not effective so has been reevaluated. R1 was noted to he catheter on floor and during calcatheter tubing was taught being far which could've dislodged the Also noted was staff holding calcabove bladder to drain contents these are great concerns and simmediately were educated on infection and lack of dignity the mistakes cause to the resident 4/17/2018 bowel and bladder a completed, and resident and stinterview completed to determing plan more effective since new of gathered to toilet and change up before meals and before bed wadded at 12 and 4 am for R9 and have been ensuring safe cather handling on R1. Care sheets and	ave res res res res res res res res res re		
	room independent R9 sat in a station -At 8:28 a.m. R9 F chair in the dining -At 8:45 a.m. R9 s independently and stationary chair in -At 9:02 a.m. R9 r -At 9:21 a.m. R9 -At 9:23 a.m. R9 r -At 9:37 a.m. R9 r -At 9:56 a.m. R9 r -At 10:07 a.m. R9 -At 10:12 a.m. R9	emained seated. remained seated. emained seated. emained seated.		plans updated.  2. Because all residents are reservaluated regularly, and many changes in overall condition all potentially affected by the cited DON reviewed with staff approprograms for residents they confind saturated in bed or wheeld current residents assessed for via bowel and bladder assessmappropriate interventions for too check and changing have been place. Care sheets updated any plan. No other residents were at the policy on toileting — bowel bladder assessments has been	d hy have are deficiency. oriate his stently hair. All continence hents and leting or put in d care and		

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u>OMB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		245540	B. WING		03/	29/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	O DELLA DIL ITATIONI O	LIEAL THOADE OFNITED		907 MARSHALL AVENUE, PO BOX 57		
HENNING	S REHABILITATION &	HEALTHCARE CENTER		HENNING, MN 56551		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		JLD BE	(X5) COMPLETION DATE
F 690	approached R, talke with R9 to his room large sagging area At 10:18 a.m. RN-I bathroom, and he acued R9 to sit on the eating a piece of ch-At 10:21 a.m. after candy, R9 stood from hall, and asked "who large, sagging bulgous remained present. The room and into the housed R9 to use the characteristic At 10:24 a.m. R 9 control of the common characteristic At 10:52 a.m. the sassist R9 to toilet. A room, and cued R9 pulled down R9's paper of the complete of the c	ed with him briefly and walked I. R9 was observed with a in his pants, between his legs. B offered R9 to use the accepted. At that time, RN-B is bed until he had finished accolate candy. R9 had finished eating the om the bed, he pointed to the are do I go out there?" The ing area in R9 's pants RN-B assisted R9 out of his itall. RN-B had not assisted or bathroom. walked to the brown leather in area and sat down. surveyor prompted staff to NA-A walked with R9 to his to go into the bathroom. NA-A ants and saturated incontinent the toilet and urinated as NA-A etely saturated brief.  3 a.m. NA-A verified R9's was soaked and hung down use to the weight of the dicated staff were to offer R9 every two hours because he	F 6	,	on of the all staff opropriate and dry skin grity as re and uring ag will of raging as they aff o a. Staff sing fon of the dents or have blan in oriately. At a will changes: residents of the dents or have blan in oriately. At a will changes: residents of the dents of the dents or have blan in oriately. At a will changes: residents of the dents of the den	
	On 3/28/18 at 1:29	n m NA-B identified R9		residents. Also audit staff with cares 3x per week for 4 weeks t		

required staff assistance with toileting and were

resident weekly for 2 months to ensure

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245540	B. WING		03/	29/2018	
	PROVIDER OR SUPPLIER  G REHABILITATION 8	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE 907 MARSHALL AVENUE, PO HENNING, MN 56551	E, ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 690	to check with R9 e use of the toilet or NA-B indicated state to care for all reside not assisted R9 with Con 3/28/18, at 1:39 not aware R9 had manor. RN-B indicated to follow the care directly who required staff identified timely tookeep R9 clean and issues.  On 3/28/18, at 1:59 (DON) indicated to for each resident be needs with a three bowel and bladder were expected to a the time frame directly considered the time frame directly considered the state of the state	very two hours to assist with to have his brief changed. If worked together as a team ents, however; stated she had the toileting needs today.  P.p.m. RN-B indicated she was not been toileted in a timely ated staff were expected to exted by the care plan for R9 assistance with toileting. RN-B leting was important in order to dry and to prevent skin  P.p.m. The director of nursing illeting plans were developed by identifying the individual day study of the residents pattern. The DON verified staff assist residents with cares in exted by the care plan. The and a half hours was too long been assisted with toileting	F6	compliance. Any defic corrected on the spot, the quality-assurance documented and subn quality-assurance comfurther review or correst. DON will be response.	and the findings of checks will be nitted at the monthly nmittee meeting for ctive action.		

STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245540	B. WING _		03	3/29/2018		
	PROVIDER OR SUPPLIER	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551	E			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 690	Continued From p	page 45	F 69	0				
	prevention of assinfections 2009, uproper techniques Maintenance inclubelow the level of not rest the bag on R1's quarterly Mirassessment, date diagnoses which is stream, frequency was cognitively in assistance with be hygiene. R1's ME an indwelling cath	nimum Data Set (MDS) d 12/23/17, identified ncluded dysuria, poor urinary and urgency of urination. R1 tact and required extensive ed mobility, dressing and DS further identified the use of eter.						
	an indwelling cath bladder. The care free from catheter various interventic catheter bag and bladder and away monitor intake and The facility nursin undated, identified	odated 3/24/18, indicated use of leter related to a neurogenic e plan indicated R1 would be related trauma and listed ons which included to position tubing below the level of the from entrance room door and doutput per facility policy.  If a ssistant care sheets, untitled, the R1 had a foley catheter. The further instructions for care of						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI		DNSTRUCTION		E SURVEY IPLETED
		245540	B. WING			03/:	29/2018
	PROVIDER OR SUPPLIER  G REHABILITATION 8	HEALTHCARE CENTER		907 M	ET ADDRESS, CITY, STATE, ZIP CODE IARSHALL AVENUE, PO BOX 57 NING, MN 56551		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	back on the bed. Fe to the bed frame, u was present in the hall, while R1's room. On 3/28/18, at 9:34 a catheter bag attached amber urine was vicatheter bag was vithe hallway. R1's of the bottom 1/3 of the back in his bed, eye bedding. nursing a entered R1's room. observed running fithe catheter bag, which was bed, uncovered and lower 1/3 of the back cloth bag attaindicated they should and she removed it hooked the catheter retrieved a plastic of from the bathroom stood next to R1's but the level of her hips bed, a foot lower the NA-B proceeded to raise to the level of feet higher than R1 wipe and cleansed it and allowed the unheld by NA-E at was	a.m. R1 was lying on his bed R1's catheter bag was attached incovered. Dark amber urine bag and was visible from the m door was opened wide.  a.m. R1 was lying in bed, with ched to the bed frame. Dark sible in the bag, and the isible through the door from eatheter bag was uncovered, he bag was rested on the floor.  6 a.m. R1 was lying on his es open, covered with a ssistant (NA)-B and NA-E. His catheter tubing was from under his blanket, down to hich was unhooked from the directed on the floor with the gresting on the floor. NA-E ter bag, then placed it in a sched to the bed frame. NA-B and the directed with the graduate measuring device and handed it to NA-E. NA-E and held the graduate at a sched to drain into the graduate. Pick up the catheter bag, her chest, approximately 2 lying in bed, used an alcohol the drainage tube, unclamped urine to drain into the graduate ist level. After the catheter and hooked the catheter bag to	F 6	90			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245540	B. WING		03	/29/2018
	PROVIDER OR SUPPLIER  G REHABILITATION	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 907 MARSHALL AVENUE, PO BOX 5 HENNING, MN 56551	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 690	the bed frame on assisted R1 to turn side, while the cat to the right side of was stretched taut to left side. After I catheter tubing wa R1 back to his back and laid it by R1's back to his left sid perineal cares. At onto the bed frame NA-B and NA-E coassisted R1 to turn other side. Again tight, and NA-E sa Again they assisted bag from the left srolled him to his riccatheter bag to his On 3/28/18, at 2:0 usual practice to einvolved two staff: while the other per NA-B indicated she height a catheter is confirmed R1's caduring the cares. I should be placed indicated she did mas resting on the On 3/28/18, at 2:1 not usually performed R1's cabladder while she	R1's right side. NA-B and NA-E in towards NA-B onto his left heter tubing was still attached his bed. The catheter tubing when R1 was assisted to roll NA-E and NA-B noticed R1's is stretched taut, they assisted ock. NA-E unhooked the bag feet. They again turned R1 is towards NA-B and performed that time NA-B hooked the bag on R1's left side of the bed. In the his right side to cleanse his R1's catheter tubing was pulled id R1's catheter was "pulling." If the his back, unhooked the ide of the bed-frame, then ght side and attached his is right side.  D5 p.m. NA-B indicated her impty R1's catheter bag one person held the graduate, reon drained the catheter bag. In the high tight was pulled tight was pulled tight was indicated R1's catheter in the cloth cover bag and not notice R1's catheter bag.	F 6	90		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG	, ,	TE SURVEY MPLETED
		245540	B. WING _		03	/29/2018
	PROVIDER OR SUPPLIER  GREHABILITATION 8	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		
(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 (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	On 3/29/18, at 1:08 (DON) identified in done when providir tugging or pulling or sure it was secure, resident's bladder a was not resting on would expect those followed during cat!  The facility policy tid dated 12/27/17, individed 12/27/17, individed held or positione prevent urine in the flowing back into the instructed staff to a off the floor.  Pharmacy Srvcs/Pr CFR(s): 483.45(a)( §483.45 Pharmacy The facility must prodrugs and biological them under an agre §483.70(g). The facility must prodrugs and biological series assure the accidispensing, and adbiologicals) to meet §483.45(b) Service	p.m. director of nursing apportant things that must be a catheter cares included; no f the catheter tubing, to make keep the bag lower than the and to assure the catheter bag the floor. DON indicated she procedures should be neter cares.  Itled Urinary Catheter Care, licated the catheter bag must be lower than the bladder to tubing and drainage bag from the urinary bladder. The policy ssure catheter bags were kept to cocedures/Pharmacist/Records b)(1)-(3)	F 69			5/4/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING		X3) DATE SURVEY COMPLETED	
		245540	B. WING		03/29/2018	
	PROVIDER OR SUPPLIER	& HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		DE	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		N
F 755	§483.45(b)(1) Provaspects of the provide facility.  §483.45(b)(2) Esta receipt and disposs sufficient detail to reconciliation; and §483.45(b)(3) Deta order and that an a is maintained and This REQUIREME by: Based on observareview, the facility accurate accountine mergency kits (Ediversion.  Findings include:  On 3/27/18 at 2:52 room tour was con (RN)-A. Located in area was a gray mby RN-A as the face medication box A (was secured with a attached to the classifip had the number strip.  Review of the facility for Security Tag No Medication Monito entry was dated 7/	vides consultation on all vision of pharmacy services in ablishes a system of records of ition of all controlled drugs in enable an accurate ermines that drug records are in account of all controlled drugs periodically reconciled. ENT is not met as evidenced ation, interview, and document failed to ensure a system for ag of medications in 1 of 1 -Kit) to prevent potential loss or expenses a cupboard above the sink etal box which was identified cility emergency stock E-Kit). The gray metal box a white plastic strip/lock sp of the box. The white plastic per 0037535 on the tab of the city log titled, Emergency Box armber and Out-Dated ring revealed the most recent 15/16. Review of an untitled 3 facility used to track medication	F 75	This Plan of Correction constitutes written allegation of compliance for the deficiencies cited. However, submists of this Plan of Correction is not an admission that a deficiency exists of one was cited correctly. This Plan of Correction is submitted to meet requirements established by state a federal law.  1. It is the policy of the facility to end the drug records are in order. The facility e-kit was noted to not have the tag documented upon arrival from the pharmacy to confirm it was the original supplied on arrival thus making it diffused to note what had been taken out or switched when a medication removed. The surveyor precluded this potential could lead to possible drug diversion record log did accurately list medical that had been removed based on documentation and did note the documented number of the new ties place. Upon determining there could	he sion  that f  and  assure ty  all tie ficult  all y  a — the tions  put in	

	R/SUPPLIER/CLIA CATION NUMBER:	· ′	IPLE CONSTRUCTION NG	1, ,	E SURVEY IPLETED
	245540	B. WING _		03/	29/2018
NAME OF PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		20/2010
			907 MARSHALL AVENUE, PO BOX 57		
HENNING REHABILITATION & HEALTHCA	RE CENTER		HENNING, MN 56551		
(X4) ID SUMMARY STATEMENT OF DE PREFIX (EACH DEFICIENCY MUST BE PRE TAG REGULATORY OR LSC IDENTIFYIN	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
taken out of the E-Kit indicated Doxycycline 100 milligrams (my tablets was taken and a plastic replaced with the number 3086 match the current strip/lock cur the E-Kit. No further documenta regarding the replacement or s E-Kit was found in the notebook.  At 3:10 p.m. RN-A confirmed the and called the pharmacy to see had been switched out. The pherenal been switched out. The pherenal been switched out indicated the facility did not log when pharmacy switched the Ewas aware of. RN-A indicated the E-Kits numbers in the past but for along time.  On 3/27/18 at 3:18 p.m. consult (CP) indicated he thought E-Kit out with E-Kit B on 3/15/18. PT the E-Kits were brought over to open the cupboard, put the new cupboard and take the old one the pharmacy. The CP indicate not track anything when switchi and did not track any of strips/locks and the above findicated the facility had not track at strips/locks since 2016, almost DON verified the strips were not E-Kits were switched out and in had stopped doing it. The DON strips/locks needed to be tracked drug diversion and indicated it is	g) times five strip had been 618, which did not rently attached to ation was found ecuring of the K.  The above findings when the E-Kit narmacy indicated /23/18. RN-A the strips/lock -Kits out, that she had not done this ting pharmacist A was switched D indicated when the facility, they w E-Kit in the with them back to d the facility did ng out the E-Kits ocks at all.  For of nursing dings and cked the 2 years ago. The at tracked when the idicated the facility indicated the ed due to potential	F 75	diversion it was determined eve-kit would be logged upon arri 2. Because all staff have accee-kit the undocumented receiving e-kit has the potential to affect residents if medications they not available due to missing medias staff dispensing meds and accee-kit will be reminded to log all they are delivered to the facility policy on medication reconciliar reviewed and updated to include the number upon receipt. No otheresidents were affected.  3. To enhance currently compoperations and under the direct director of nurses, on 4/24/201 nursing staff was in-serviced of e-kits upon entry to facility.  4. Effective 4/17/2018, a quality-assurance program was implemented under the supervent director of nurses to monitor eupon entry and each time it is on when opened to remove a medication of the DON or designee will compandits per week x 4 weeks, the weekly x2 months to ensure conformed to the findings of the quality-acceptation of the quality-acceptation of the quality-acceptation of the quality-acceptation of the quality-acceptation.  5. Pharmacy and DON will be responsible for this POC.	val. ess to the ng of the all eed are not tions. All essing the e-kits as a tion was le logging her bliant tion of the 8 all hologging her bliant tion of the kit ties changed lication. plete 2 n 1 audit empliance d y n the spot, assurance d submitted se review or	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		E SURVEY IPLETED
		245540	B. WING _		03/	29/2018
	PROVIDER OR SUPPLIER  G REHABILITATION &	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		
(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 CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 758 SS=D	Reconciliation date facilty will document booklet to confirm addition when the living confirm the ide facility log. Further would review the eas well as any reconfirmed facility log. Further would review the eas well as any reconfirmed for the facility log. Further would review the eas well as any reconfirmed for the facility shall be	ity policy titled, Medications ed "12/27/18", identified the ent the identificaiton number in a the E-Kit was locked. In box is relocked the pharmacy ntification number matches the the policy listed the facility -kit contents annually in QAPI oncillation errors. Psychotropic Meds/PRN Use (3)(e)(1)-(5)  otropic Drugs. ychotropic drug is any drug that ites associated with mental navior. These drugs include, to, drugs in the following  t; ehensive assessment of a y must ensure that idents who have not used are not given these drugs tion is necessary to treat a as diagnosed and documented	F 75			5/4/18

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	PROVIDER OR SUPPLIER  REHABILITATION	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551	·	
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F 758	psychotropic drug unless that medic diagnosed specific in the clinical reconstruction with the clinical reconstruction of th	sidents do not receive is pursuant to a PRN order ation is necessary to treat a condition that is documented rd; and  N orders for psychotropic drugs ays. Except as provided in the attending physician or ioner believes that it is a PRN order to be extended the or she should document their sident's medical record and on for the PRN order.  N orders for anti-psychotic to 14 days and cannot be the attending physician or ioner evaluates the resident for that medication.  ENT is not met as evidenced ation, interview, and document failed to ensure target entified, monitored, and use of Seroquel (anti-psychotic of 5 residents (R15) reviewed	F 75	This Plan of Correction constitution allegation of compliance deficiencies cited. However, sut of this Plan of Correction is not admission that a deficiency exist one was cited correctly. This Plan Correction is submitted to meet requirements established by statederal law.  1. It is the policy of the facility guidelines regarding use of psymedications. R15 has Lewy book dementia with behavioral disturb	for the omission an sts or that lan of ste and to follow chotropic dy	
	The MDS identifie	d R15 required assistance with ving (ADL) such as, supervision		Seroquel was ordered however behaviors were listed nor docum	no target	

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		•		907 MARSHALL AVENUE, PO BOX 57		
HENNIN	G REHABILITATION	& HEALTHCARE CENTER		HENNING, MN 56551		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (CEACH CORRECTIVE ACTION SHOUTH CORRESTIVE ACTION SHOUTH CORREST CORREST CORRECTIVE ACTION SHOUTH CORREST CORRECTIVE ACTION OF THE APPORT OF TH	OULD BE	(X5) COMPLETION DATE
F 758	Continued From processing to transfers, walk extensive assistar dressing, toileting MDS indicated R1 symptoms not dire on 1-3 days of the MDS further ident anti-psychotic meanti-depressant mati-depressant mati-psychelms, but did potential problems pre-populated dat received anti-psychallucinations, how or complete an armedication, or half size care plan is included: administration ordered by physic effectiveness, comphysician to consicinically appropria	ing and eating, and required noe from staff for bed mobility, and personal hygiene. The 5 had hallucinations, behavioral ected at others and wandered 7 day assessment period. The iffed the use of a daily dication and a daily dedication.  Assessment (CAA) dated diagnoses of dementia and se and a potential for behavioral not indicate the nature of the The CAA identified (through a entered into the MDS) R15 chotic medication and had wever the CAA did not identify allysis of the anti-psychotic	F 75	DEFICIENCY)	ces. When let let was let let was let let was let let arget let aware to det monitor dated care let ave orders let are let ave orders let ave	
	attempted and the policy, educate ab monitor/document of psychotropic m lacked identification	peir effectiveness as per facility sout risks and benefits and threport any adverse reactions edications. R15's care plan on of targeted behaviors and ical interventions to use for the		determine need, effectiveness reduction and ensure target be listed for nursing to document oplan.  4. Effective 4/17/2018, a quality-assurance program was implemented under the supervidirector of nurses to monitor re	or dose naviors on per care sion of the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	` ′	SURVEY PLETED
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HENNIN	G REHABILITATION	& HEALTHCARE CENTER			7 MARSHALL AVENUE, PO BOX 57 ENNING, MN 56551		
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F 758	R15's signed Physincluded Seroquel evening for Lewy Idementia with beh 9/6/17 and Seroquel Body dementia rel behavioral disturbation received of R15's madministration received Seroquel 8:00 p.m. and anti effect monitoring EMAR and ETAR's identification for S A request for behavioral for Seroquel And the series of the serie	sician Orders dated 1/30/18, 12.5 milligram (mg) in the Body dementia related to avioral disturbance, ordered on lel 25 mg at bedtime Lewy ated to dementia with ance, ordered on 9/6/17.  Inonthly electronic medication ord (EMAR) and electronic tration record (ETAR) from March 2018, revealed R15 twice daily, at 4:00 p.m. and psychotic medication side each shift. However, R15's a lacked target behavior eroquel use.	F 7	58	with orders for psychotropic meds. director of nurses or designated quality-assurance representative w perform the following systematic auresidents with orders for psychotrol and target behaviors to be assesse care planning, pharmacy review, ar target behavior monitoring; 5 reside per week x 4 weeks, then 3 resider weekly x2 months to ensure compl in this area. Any deficiencies will be corrected on the spot, and the findithe quality-assurance checks will be documented and submitted at their quality-assurance committee meetifurther review or corrective action.  5. The Pharmacy, SW and DON viewponsible for this POC.	ill udits on oics ed for nd ents nts iance engs of e monthly ng for	

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F 758	able to follow simple activities of daily libehaviors, was property at 9:05 a.m. R15 of staff assisted to see completed breakfa bathroom and the walked to an arm At 10:12 a.m. R15 chair with head be chest.  On 3/29/18, at 3:3 arm chair in the day down and chin was seated quietly with On 3/29/18, at 3:3 stated R15 receives behaviors and indivandering. RN-As mannerisms than  On 3/29/18, at 3:4 with his head down NA-C stated R15 wandering a little, On 3/29/18, at 3:5 nursing (ADON) sibehaviors for Sercorders or the care R15 had no behaviors of stated the files.	ole directions and assist with ving. NA-B stated R15 had no etty quite and was "sweet."  was eating independently after et up the meal. After R15 ast, staff assisted him to the hack to the day room. R15 chair with staff and sat down. The remained seated in the arm ent down and chin tucked to chest. R15 was a visitor seated to the left.  4 p.m. registered nurse (RN)-A ed Seroquel for dementia with stated the target behavior was estated R15 had more behaviors.  4 p.m. NA-C stated R15 walked and would walk into things. displayed a behavior of but was redirectable.  5 p.m. assistant director of tated R15 had no targeted oquel identified on the physician plan. The ADON confirmed	F 758			

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			(X3) DATE SURVEY COMPLETED		
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			907 MARSHALL AVENUE, PO BOX	CODE			
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review the EMAR behaviors and the SSD confirmed R'behavior monitoring really have behavion was easily redirect on 3/29/18, at 4:1 (DON) stated R15 psychosis related stated R15's care for use of an anti-expect them to be staff knew what to EMAR and confirm Seroquel use. The daily monitoring for anti-psychotic medical on a staff are giving on 3/29/18, at 4:3 registered nurse (was ordered for psychotic medical and the staff are giving on 3/29/18, at 4:4 (CP) stated the user of a staff are giving on 3/29/18, at 4:4 (CP) stated the user of a staff and irredication regime CP stated if an irredication regime appropriate indication anti-psychotic medication regime appropriate indication regime a	and progress notes for in update providers as needed. 15's EMAR lacked targeting. SSD stated R15 does not iors, except wandering and R15 ited.  2 p.m. director of nursing is Seroquel was ordered for to Lewy Body dementia. DON plan lacked targeted behaviors psychotic medication and would it on R15's care plan, so that it monitor. DON reviewed R15's med it lacked monitoring for it DON stated she would expect or the indicated use of an idication.  3 p.m. advanced practice APRN) stated R15's Seroquel sychosis related to Lewy Body stated R15's target behavior is. APRN stated he would expect intoring being completed on R15 him a report prior to his visit.  1 p.m. consultant pharmacist is sual practice of the CP was to lent's medical chart for a gen review on a monthly basis. Engularity was found, a would be made. CP stated dications are reviewed for tion for use, monitoring for		,				
	ROVIDER OR SUPPLIEF  REHABILITATION  SUMMARY ST (EACH DEFICIENT REGULATORY OR  Continued From preview the EMAR behaviors and the SSD confirmed R behavior monitoring really have behav was easily redirect on 3/29/18, at 4:1 (DON) stated R15 psychosis related stated R15's care for use of an antiexpect them to be staff knew what to EMAR and confirm Seroquel use. 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SSD confirmed R15's EMAR lacked target behavior monitoring. SSD stated R15 does not really have behaviors, except wandering and R15 was easily redirected.  On 3/29/18, at 4:12 p.m. director of nursing (DON) stated R15's Seroquel was ordered for psychosis related to Lewy Body dementia. DON stated R15's care plan lacked targeted behaviors for use of an anti-psychotic medication and would expect them to be on R15's care plan, so that staff knew what to monitor. DON reviewed R15's EMAR and confirmed it lacked monitoring for Seroquel use. The DON stated she would expect daily monitoring for the indicated use of an anti-psychotic medication.  On 3/29/18, at 4:33 p.m. advanced practice registered nurse (APRN) stated R15's Seroquel was ordered for psychosis related to Lewy Body dementia. APRN stated R15's target behavior was hallucinations. APRN stated he would expect	ROVIDER OR SUPPLIER  SERHABILITATION & HEALTHCARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 56  review the EMAR and progress notes for behaviors and then update providers as needed. SSD confirmed R15's EMAR lacked target behavior monitoring. SSD stated R15 does not really have behaviors, except wandering and R15 was easily redirected.  On 3/29/18, at 4:12 p.m. director of nursing (DON) stated R15's Seroquel was ordered for psychosis related to Lewy Body dementia. DON stated R15's care plan lacked targeted behaviors for use of an anti-psychotic medication and would expect them to be on R15's care plan, so that staff knew what to monitor. DON reviewed R15's EMAR and confirmed it lacked monitoring for Seroquel use. The DON stated she would expect daily monitoring for the indicated use of an anti-psychotic medication.  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CP stated anti-psychotic medications are reviewed for appropriate indication for use, monitoring for benefit, side effect monitoring and potential	ROVIDER OR SUPPLIER  3 REHABILITATION & HEALTHCARE CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 56 review the EMAR and progress notes for behaviors and then update providers as needed. SSD confirmed R15's EMAR lacked target behavior monitoring. SSD stated R15 does not really have behaviors, except wandering and R15 was easily redirected.  On 3/29/18, at 4:12 p.m. director of nursing (DON) stated R15's care plan lacked targeted behaviors for use of an anti-psychotic medication and would expect them to be on R15's care plan, so that staff knew what to monitor. DON reviewed R15's EMAR and confirmed it lacked monitoring for Seroquel use. The DON stated she would expect daily monitoring for the indicated use of an anti-psychotic medication.  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		245540	B. WING		03/	29/2018
	PROVIDER OR SUPPLIER  G REHABILITATION 8	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		
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F 758	behavior monitoring be monitoring psychot	p. CP stated the facility would nosis.	F 7	58		
	Food Procurement, CFR(s): 483.60(i)(1	, , ,	F 8	12		5/4/18
	§483.60(i) Food sat The facility must -	ety requirements.  Eure food from sources				
	approved or consid state or local autho (i) This may include from local producer and local laws or re (ii) This provision defacilities from using gardens, subject to safe growing and for (iii) This provision defacilities	ered satisfactory by federal, rities. I food items obtained directly s, subject to applicable State				
	serve food in accor standards for food s This REQUIREMEN by: Based on observat review, the facility for ice machine to prevall 22 residents (R1 R9, R10, R11, R12	e, prepare, distribute and dance with professional service safety.  NT is not met as evidenced ion, interview and document ailed to maintain the water and tent potential contamination for , R2, R3, R4, R5, R6, R7, R8, R13, R14, R15, R16, R17, 2, R124) who currently resided		This Plan of Correction constitu written allegation of compliance deficiencies cited. However, sub of this Plan of Correction is not a admission that a deficiency exist one was cited correctly. This Plan Correction is submitted to meet	for the mission an is or that	
	Findings include:			requirements established by star federal law.	te and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		SURVEY PLETED
		245540	B. WING			03/2	29/2018
	PROVIDER OR SUPPLIER  G REHABILITATION &	HEALTHCARE CENTER		9	TREET ADDRESS, CITY, STATE, ZIP CODE 07 MARSHALL AVENUE, PO BOX 57 IENNING, MN 56551		
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F 812	the facility, a water main dining room on have a crusted hard under the ice and walso noted to have and heavy hard watthe entire outer edgresident refrigerator room was observed lime scale build up dispenser and the tright water lime scale build up dispenser and the tright water lime scale of the water and ice redining room of the free encrusted hard watthe ice and water doubted to have light heavy hard water lime entire outer edge of indicated the water and had just gotten white lime scale that the ice and water doubted the staff cleaned the veryday but felt the under the ice and water doubted the ice and water doubted the staff cleaned the veryday but felt the under the ice and water doubted the scale but dispenser and the tright water lime scale but dispenser and tright water lime scale but dispenser and tright water lime scale but dis	3 p.m. during an initial tour of and ice machine located in the f the facility, was observed to d water lime scale build up vater dispenser. The tray was light water lime scale build up ter lime scale running around the of the machine. The r located in the north family d to have encrusted hard water under the ice and water ray was also noted to have lee build up on it.  7 p.m. a tour of the kitchen at the dietary manager (DM), terns were identified: machine located in the main racility continued to have er lime scale build up under ispenser. The tray was also water lime scale build up and me scale running around the fithe machine. The DM and ice machine had a leak fixed. The DM noted flakes of at could be chipped off under ispenser. The DM indicated is e ice and water machine e staff did not think to clean	F	312	1. It is the policy of this facility to a healthy and safe meal service. Sor the many ways that this has been densuring clean environment and sapreparing and serving food and beverages to residents. After the sureported finding lime scale build up machine in dining room and north froom fridge. Although it was noted lime scale was bad within the ice mit also included outside the machine Immediately the ED and maintenant department determined necessary cleaning measures to deep clean the machine.  2. Because all residents receive the meals here in facility all are potential affected by the cited deficiency, 4/4 the dietary manager along with ED deep clean of both ice machines. So deep clean lime scale has been cleaned every 6 months unless not need sooner. Policy on cleaning ice machines was reviewed.  3. To enhance currently compliant operations and under the direction director of dietary, on 4/24/2018, all that serve residents ice water or an item were in-serviced on the import of updating dietary manager or ED note any appliance, machine, or are touches residents food or drink has visible scale, rust or debris that cout to bacteria.  4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision director of dietary to monitor lime so implemented under the supervision director of dietary to monitor lime so implemented under the supervision director of dietary to monitor lime so implemented under the supervision director of dietary to monitor lime so implemented under the supervision director of dietary to monitor lime so implemented under the supervision director of dietary to monitor lime so implemented under the supervision director of dietary to monitor lime so implemented under the supervision director of dietary to monitor lime so implemented under the supervision director of dietary to monitor lime so implemented under the supervision director of dietary to monitor lime so implemented under the supervision director of dietary to monitor lime so implemented under the supervision	ne of one is fely urveyor on ice amily the achine e. ice ne heir ally /2018, did do ince ar. The deep ed to e to fel staff y food cance if they ea that any ald lead of the	

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		245540	B. WING		03/:	29/2018
	PROVIDER OR SUPPLIER  G REHABILITATION 8	& HEALTHCARE CENTER	9	STREET ADDRESS, CITY, STATE, ZIP CODE 2007 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 881	building. The DM v resident three time meal and indicated machines were that On 3/27/18 at 1:24 confirmed staff pass both locations three rooms and confirm Review of facility porceasing Policy, creensure ice machine germs from day to machine operating machines outside, cleaned daily, and should be done ins Antibiotic Stewards CFR(s): 483.80(a) (Section 1988) (Sect	both locations within the erified staff pass water to the s a day in rooms, at every she did not realize the ice at "bad" with buildup.  p.m. nursing assistant (NA)-as water to the residents from the times a day for water in their ed the above findings.  colicy titled, Ice Machine eated on 3/27/18, identified to edoes not have unsanitary day operations and to keep at optimum level, ice tray and dispensers were to be every 6 months a deep clean side and out.  Ship Program (3)  In prevention and control establish an infection prevention of (IPCP) that must include, at lowing elements:  Intibiotic stewardship program otic use protocols and a antibiotic use.  NT is not met as evidenced of an antibiotic stewardship did the potential to affect all 22	F 812	build up on ice machines. The didietary or designated quality-assure representative will perform audits machines to be done 2x per week weeks then 1x per week for 2 morensure compliance via dietary madesignee. Any deficiencies will be corrected on the spot, and the fine the quality-assurance checks will documented and submitted at the QAPI meeting for further review of corrective action.  5. Dietary manager and mainter will be responsible for this POC.	es my or the nission	5/4/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION  NG		E SURVEY PLETED
		245540	B. WING _		03/2	29/2018
	PROVIDER OR SUPPLIER	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
IILIAIAIIA	GILLIABILITATION	& TILALITICANE CENTEN		HENNING, MN 56551		
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F 881	Findings include;  A review of the factor surveillance prograt 8:35 a.m. and infunctioning antibic infection control program and infunctioning antibic infection control program also lack and symptoms, lateral antibiotic use and identified.  The facility forms included the follow microbiology test antibiotic order, strumber of days a start date to stop line-list/log, Is Loe initiation of antibiotic revealed;  -November 2017, with antibiotics, for the facility forms included the follow microbiology test antibiotic order, strumber of days a start date to stop line-list/log, Is Loe initiation of antibic revealed;	cility's infection control ram was conducted on 03/29/18, dentified the facility lacked a otic stewardship program. The rogram lacked protocols for a m to monitor the use of ng (but not limited to) ribing of antibiotics and periodic c use by physicians. The need protocols for review of signs bes, determination of appropriate reporting of any patterns  titled Essential Data, undated, wing; date/resident, indication, results, type/route/frequency cart date, stop date, DOT (actual ntibiotic was used, should equal date) infection surveillance be minimum criteria met (for	F 8	,	eet r state and lity to follow ic ntation of this cilities must iotic cludes a system to orogram has use for all tics. s use ally affected esidents on red for as are infection. No d. The policy ring has been mpliant rection of the 018 all viced on propriate b. Antibiotic ediately upon urse will	
	test results, and o hospital discharge and symptoms we criteria met, and o (N/A). The form la	ne indicated positive lab from e. Antibiotics used were listed ere listed. Two indicated Loeb one indicated non applicable acked identification of pathogen, and analysis of data.		place.  4 Effective 4/17/2018, a quality-assurance program vimplemented under the superinfection control nurse to more residents with orders for antinfection control nurse or design and the superinfection control nurse or design.	vas ervision of the enitor ibiotics. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	` ′	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245540	B. WING		03/:	29/2018	
	PROVIDER OR SUPPLIE	R I & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 907 MARSHALL AVENUE, PO BOX HENNING, MN 56551	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 881	-December 2017 antibiotics, two for two for urinary traprophylactic use positive lab result admission. Antibentries indicated two indicated the identification of panalysis of data.  -January 2018, or cellulitis. The for symptoms, and incriteria was not midentification of panalysis of data.  -February 2018, treated for UTI arindicated Klebsie pseudomonas autest results, and iminimum criteria. documented as pN/A for microbiololacked sensitivity  -No March 2018 to CDON) confirmed infection control pantibiotic steward RN-C was new to herself. DON inditte nursing staff without reviewing	page 61 , six residents listed to use or pneumonia, one for C-Diff, act infection (UTI) and one for con admission. Two indicated its and four indicated N/A on indicts used were listed. Four N/A for Loeb criteria met, and y did not. The form lacked athogen, sensitivity reports and one resident listed as treated for m listed antibiotic use and indicated the Loeb minimum inter. The form lacked athogen, sensitivity reports and involved its were listed as indicated it met the Loeb's. The respiratory. The form la pneumoniae and interesting it met the Loeb's. The respiratory was one umonia on admission and orgy test results. The form report and analysis of data.  If orm was provided.  2:57 p.m. director of nursing RN-C was responsible for the program which included the liship program. DON confirmed on her position and had trained cated at the beginning of March, were not to start an antibiotic it with RN-C first. DON thibitic stewardship program was the program was t	F8	quality-assurance represel perform the following systeresidents with antibiotics of their organism has been their organism has been the resident weekly x2 months compliance in this area. At will be corrected on the specific findings of the quality-assurance meeting for further review action.  The Pharmacy and infinurse and DON will be resported.	ematic audits on orders, and that racked; 3 eks, then 1 s to ensure ny deficiencies ot, and the urance checks ubmitted at the committee or corrective		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		245540	B. WING		03/29/2018
	PROVIDER OR SUPPLIER  G REHABILITATION 8	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 881	registered nurse (R facility infection preshe had just begun program, and had to infection control nuspoken to the nurse regarding criteria be indicated this was reindicated some of to alternative treatmentall were on board you not consistently obtoes ensitivity reports of the program was stopped.	a 3/29/18, at 8:35 a.m.  RN)-C indicated she was the vention nurse. RN-C indicated the antibiotic stewardship trained herself for the role of the role	F 881		
F 908 SS=D	Program, undated, antibiotic stewardsl leadership commitrexpertise, action, treducation. The antincluded the medicipharmacist, director prevention nurse. Essential Equipmer CFR(s): 483.90(d)(S483.90(d)(2) Main and patient care expected in the condition. This REQUIREMED by:  Based on observative review, the facility for the committee of the condition of the condition of the condition.	tled Anti-microbial Stewardship listed the core elements of the nip program which included; ment, accountability, drug acking, reporting and tibiotic stewardship team al director, consulting of nursing and infection nt, Safe Operating Condition 2)  tain all mechanical, electrical, juipment in safe operating  NT is not met as evidenced tion, interview and document ailed to maintain equipment in anner for 1 of 1 resident (R19)	F 908	This Plan of Correction constitutes written allegation of compliance for deficiencies cited. However, submis	the

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			E SURVEY PLETED
		245540	B. WING _		03/	29/2018
NAME OF F	PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, STATE, ZIP COL	•	
HENNING	G REHABILITATION	& HEALTHCARE CENTER		907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 908		•	F 90	of this Plan of Correction is no	ot an	
	who had a broken wheelchair.  Findings include:			admission that a deficiency ex one was cited correctly. This Correction is submitted to me	xists or that Plan of	
		mum Data Set (MDS) dated intact cognition and diagnoses miplegia.		requirements established by seed federal law.  1 It is the policy of the facility maintain all patient care equipments.	state and ty to	
	chair needed to be left leg rest was be replaced because broken, sharp me knew the facility wand had indicated plan was to purch.	59 p.m. R19 stated her wheel e repaired. R19 indicated the roken and needed to be she had cut her leg on the tal two times. R19 indicated she ras aware of the broken leg rest for the past two months the ase a new wheel chair, ty had not replaced the		operating condition. When su that R19 had reported a broke wheelchair and foot pedal, it was determined resident needed resident needed resident ordered for her sa comfort.  2. Because many residents wheelchairs or patient care expanded and are potentially affected deficiency, staff were reminded all residents have safe working that R19 had been safe working operating the same safe working operating the safe working operat	rveyor noted en was new fety and use quipment, by the cited ed to ensure	
	following: "Note To assistant) reported	ote dated 3/13/18, revealed the ext: CNA (certified nursing d scratch on outer left leg from Was bleeding. Area cleaned		equipment. All resident □s where audited for safety, clean good working order. No other were affected. The policy on waintenance has been updated.  3. To enhance currently come	lliness and residents wheelchair ed.	
	and NA-D transfer the use of a full be noted to be in poor place R19's left le repeatedly before place. NA-A held to place on the metal a pillow onto the co onto the leg rest.	7 a.m. nursing assistant (NA)-A red R19 to her wheelchair with ody lift. The left leg rest was r repair. NA-A attempted to g on the wheelchair leg rest able to keep the leg rest in the black padded foot cradle in I bars of the the leg rest, placed radle and then placed R19's leg		operations and under the director of nurses, on 4/24/20 received in-serviced on whee proper working order, safe pa and cleanliness. The training include understanding that all equipment is in safe operating 4. Effective 4/17/2018, a quality-assurance program wimplemented under the super executive director to monitor. The ED or designated quality-	iction of the 18 all staff lchairs    for our of the care of the c	
		vas no longer attached to R19's cated she was aware of R19's		representative will perform the systematic audits on resident		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG		E SURVEY PLETED
		245540	B. WING		03/2	29/2018
	PROVIDER OR SUPPLIE  G REHABILITATION	R & HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIF 907 MARSHALL AVENUE, PO BO HENNING, MN 56551	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 908	broken leg rest ar supervisor in the On 3/28/18, at 7:5 broken leg rest had director of nursing maintenance direbeen filled out in the Double of the Don 3/29/18, at 2:5 a new wheel chair leg remonths earlier and so old it was diffic M-A indicated in the had spoken about for R19. On 3/29/18, at 2:5 a new wheel chair leg remonths earlier and so old it was diffic M-A indicated in the had spoken about for R19. On 3/29/18, at 2:5 a new wheel chair leg remonths earlier and so old it was diffic M-A indicated in the had spoken about for R19. On 3/29/18, at 2:5 a new wheel chair leg on 3/29/18, at 2:5 repairs had been while ago and at the had recommended the Don verified ordered, therapy evaluation for R19 been requested for treatment. The Daware of recent control of the facility policy.	nd had reported it to a nursing past.  52 a.m. NA-D indicated the ad been verbally reported to the g (DON), administrator and the ctor (M)-A, and a repair slip had the past few weeks.  52 p.m. M-A indicated the usual as to inspect each resident room f were to verbally notify him or slip to alert him to needed ated he had replaced R19's est approximately four to five d explained the wheel chair was cult to find replacement parts. The past month the administrator to purchasing a new wheel chair lab p.m. the administrator verified r had not been purchased for strator indicated therapy would R19's current wheel chair and	F9	wheelchairs to ensure the and in good working order week x 4 weeks, then 1 re x2 months to ensure com area. Any deficiencies will the spot, and the findings quality-assurance checks documented and submitte quality-assurance commit further review or corrective 5. The therapy department maintenance department responsible for this POC.	r; 3 residents per esident weekly pliance in this I be corrected on of the will be ed at the monthly tee meeting for e action.	

PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  PRECULATION OF PROVIDER OR SUPPLIER  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  907 MARSHALL AVENUE, PO BOX 57  HENNING, MN 56551  ID  PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  PRESULT ACCURATE OR A COMPLETE OF THE APPROPRIATE  PAGE OF CROSS-REFERENCED TO THE APPROPRIATE  DATE  PAGE OF CROSS-REFERENCED TO THE APPROPRIATE  PAGE OF CROSS-REFERENCED TO THE APPROPRIATE  DATE  ON 129/2012  STREET ADDRESS, CITY, STATE, ZIP CODE  907 MARSHALL AVENUE, PO BOX 57  HENNING, MN 56551  (EACH CORRECTIVE ACTION SHOULD BE  COMPLETED OF THE APPROPRIATE  PAGE OF CROSS-REFERENCED TO THE PAGE OF CROSS-REFERENCED TO T	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  HENNING REHABILITATION & HEALTHCARE CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE			245540	B. WING		03/	29/2018
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE					907 MARSHALL AVENUE, PO BOX 57		
DEFICIENCY)	(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		(X5) COMPLETION DATE
F 908 Continued From page 65 policy is to keep the wheelchair clean and in good repair to prevent any accidents.  F 908	F 908	policy is to keep th	ne wheelchair clean and in good	F 9	08		

PRINTED: 05/01/2018 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245540 B. WING 03/27/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 **HENNING REHABILITATION & HEALTHCARE CENTER** HENNING, MN 56551 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PRÉFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) **TAG** TAG DEFICIENCY) K 000 | INITIAL COMMENTS K 000 **FIRE SAFETY** THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE, YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Henning Rehab & RHCC 01 Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99 Healthcare Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K TAGS) TO:** "If participating in the E-POC process, a paper copy of the plan of correction is not required."

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

TITLE

**Electronically Signed** 

04/27/2018

(X6) DATE

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.

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	IPLE CONSTRUCTION NG <b>01 - Main Building 01</b>		TE SURVEY MPLETED
		245540	B. WING		03	/27/2018
	PROVIDER OR SUPPLIER  G REHABILITATION	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		
(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 CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MULTIPLE TOLLOWING INFOLLOWING	eet, Suite 145  State.mn.us  RRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION:  what has been, or will be, done ciency.  roposed, completion date.  or title of the person rection and monitoring to rence of the deficiency  RHCC is a 1-story building with t. The building was constructed in the north of the original of the determined to be of the determined to be of the determined to be of the original of the north of the	KO			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	TIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245540	B, WING	,	_ 03	/27/2018
	PROVIDER OR SUPPLIER	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STA 907 MARSHALL AVENUE, F HENNING, MN 56551		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE O TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
	accordance with I Installation of Autofacility has a fire a detection in the cocorridors that is medepartment notific with NFPA 72 "The facility has a census of 22 at the Because the origin meet the construction buildings, the facility has a census of 22 at the Because the origin meet the construction buildings, the facility has a census of 22 at the Because the origin meet the construction buildings, the facility has a census of 22 at the Because the origin meet the construction function of the facility has a census of 22 at the Because the origin meet the construction function fu	NFPA 13 The Standard for the comatic Sprinkler Systems. The color and spaces open to the contion of automatic fire cation installed in accordance to National Fire Alarm Code".  I capacity of 42 beds and had a me of the survey.  Inal building and the additions cation type allowed for existing lity was surveyed as one  At 42 CFR, Subpart 483.70(a) is  - Maintenance and Testing  - Maintenance and Testing  - Maintenance and Testing  er and standpipe systems are and maintained in accordance and and and for the Inspection, staining of Water-based Fire ins. Records of system design, pection and testing are ecure location and readily in system last checked  I system test	ĸ	353		5/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		245540	B, WING		03/2	27/2018
	PROVIDER OR SUPPLIER  G REHABILITATION 8	HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551		
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 353	by: Based on observate facility failed to material accordance with the (NFPA 101) and Ni standard for testing systems. This defices prinkler system neallow for the spreathe 42 resident and staff and visitors.  Findings include:  On the facility tour on 03/27/2018 observed were blocked. In the basement was stacked within deflector.  In resident room curtains were in useflow.	and NFPA 25 NT is not met as evidenced tion and staff interview, the intain the sprinkler system in e 2012 Life Safety Code FPA 25 section 5.2.1.1.2. The g and maintenance of sprinkler cient condition could cause the of to function properly and d of fire. This could affect 24 of d an undetermined amount of  between 8:15 am to 11:15 am ervations revealed sprinkler d as listed. t storage room, the contents 18 inches of the sprinkler as 20, 27, and 32 solid cubicle te that could block the sprinkler	K 35	This Plan of Correction constitut written allegation of compliance of deficiencies cited. However, sub of this Plan of Correction is not a admission that a deficiency exist one was cited correctly. This Pla Correction is submitted to meet requirements established by state federal law.  1. It is facility policy per NFPA report to have all rooms with curtains how netted and all sprinklers clear witenches of a sprinkler deflector. A non-netted curtains have been the and rooms 20, 27, and 32 have been checked to ensure compliance of Maintenance Director and Execut Director. The sprinkler deflectors basement storage room have been cleared to allow 18 inches of registance. The maintenance director created in his Preventative main app, a monthly inspection task the prompts him to ensure sprinkler compliance.  2. Because all residents that resificatility calling it their home, all an potentially affected by the cited of Maintenance director reviewed a sprinkler heads and cubicle curtisoon as the deficiency was cited 3. To enhance currently compliance.	for the mission n sor that an of e and gulation ave thin 18 ll nrown out been y the ulated r has tenance at system de in the e leficiency. Il ains as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG <b>01 - MAIN BUILDING 01</b>		(X3) DATE SURVEY COMPLETED	
		245540	B. WING		03/	27/2018	
	PROVIDER OR SUPPLIEI  G REHABILITATION	& HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
K 353	Continued From p	page 4	K 353	operations the Maintenance Director reviewed all rensure all curtains were in compositive also reviewed all sprinkler compliance.  4. Effective 4/17/2018 the Maintenance of compliance with Sprinkler space and cubicle curth Audits will be performed by the maintenance director or his designative all rooms are in complianted cubicle curtains and compositive space 3 times a week the weeks then 1 time a week for 2 times and compositive all rooms are incomplianted cubicles.	enance h ains. gnee to nce with bliant or 4		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 17, 2018

Mr. Patrick Krejci, Administrator Henning Rehabilitation & Healthcare Center 907 Marshall Avenue, PO Box 57 Henning, MN 56551

Re: State Nursing Home Licensing Orders - Project Number S5540028

Dear Mr. Krejci:

The above facility was surveyed on March 26, 2018 through March 29, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the

Henning Rehabilitation & Healthcare Center April 17, 2018 Page 2

statement, "This MN Requirement 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 Gail Anderson, Unit Supervisor, at (218) 332-5140 or gail.anderson@state.mn.us.

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,

Michaelyn Bruer, Enforcement Specialist

Minnesota Department of Health Health Regulation Division

Mother

Program Assurance Unit

phone 651-201-4117 fax 651-215-9697

email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00799	B. WING		03/29/201	8
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
HENNIN	G REHABILITATION &	HEALINGARE C	SHALL AVEN 5, MN 56551	UE, PO BOX 57		
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2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correspursuant to a surve found that the deficion herein are not correspond to corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
dinnacata D	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	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				
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DA	TE

**Electronically Signed** 04/25/18

STATE FORM 6899 If continuation sheet 1 of 46 SIKJ11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED		
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2 000	Department of Hea you electronically, is necessary for Sta enter the word "corn text. You must then State licensure proceompletion date, the corrected prior to el Minnesota Departmonth on March 26, 2018 surveyors of this Deabove provider and orders are issued. Please indicate in your and identify the date Minnesota Departmonth of the State Licensing federal software. The assigned to Minnes Nursing Homes. The assigned tag in column entitled "It statute/rule out of constitute/rule out of constitute/rul	Althorders being submathough no plan of cate Statutes/Rules, planeted in the box avaindicate in the electrocess, under the headile date your orders will ectronically submitting the following corrections and the following correction or electronic plan of the following correction or electronic plan of the ewhen they will be conent of Health is docu. Correction Orders using numbers have been as the statutes/rule following correction or electronic planeted in the following correction or electronic planeted in the following correction or folial column also included in violation of the state in the following the surveyors find the surveyors find the folial correction.	orrection ease illable for onic ng l be g to the 018, ed the on orders, ompleted. menting sing n es for e far left ate the ellumn the les the e statute t as idings and of THE I." THIS	2 000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED			
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2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 545	MN Rule 4658.0400 Resident Assessme	Subp. 3 A-C Comprehensive ent; Frequency	2 545		5/4/1	18
	assessments must A. within 14 day B. within 14 day the resident's physi	cy. Comprehensive resident be conducted: as after the date of admission; as after a significant change in cal or mental condition; and every 12 months.				
	by: Based on interview facility failed to ensi Assessments (CAA analysis of a reside	and document review the ure resident Care Area a) included a comprehensive nt's needs, strengths, goals, nees for 4 of 5 residents (R9, viewed.		See State tag for Plan of Correction	<b>1.</b>	
	Findings include:					
	(MDS) dated 5/23/1 impairment and dia neurogenic bladder dementia, and anxirequired supervision and eating, and received and received, antidated R9 had be one to three times of and received, antidated R9 and received, antidated R9 had be one to three times of and received, antidated R9 had be one to three times of and received, antidated R9 had be one to three times of and received, antidated R9 had be one to three times of and received, antidated R9 had be one to three times of antidate	ange Minimum Data Set 7, identified severe cognitive gnoses which included (bladder dysfunction) ety. The MDS indicated R9 n with transfer, ambulation quired extensive assistance ersonal hygiene, The MDS ehaviors not directed at others during the assessment period epressant and diuretic ntibiotics five days and				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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2 545	antianxiety medicate R9's Care Area Ass 5/23/17, identified or from the data enter analysis. The follow Cognitive Loss/Den Functional/Rehabili Incontinence and In Symptoms, Falls, N Ulcer and Psychotro  -Cognitive Loss/De area was an actual indicate why. The Copre-populated chece entered on the MDS Neurological factors mood and behavior functional status an requiring additional cognition. The CAA analysis of the afore checkmarks which functioning. The CA considerations that functioning from res communication with staff members and care planning consi  -Communication CA an actual problem f why. The CAA reve check marked area and conditions, med of the communication additional assessm communication. Th	essments (CAA) dated ine care areas had trigged ed into the MDS requiring ing care areas were trigged entia, Communication, A tation Potential, Urinary indwelling Catheter, Behavioritional Status, Pressurbpic Drug Use.  In entia CAA revealed the problem for R9, but did not take areas (from data), which included:  Is, observable characterist, medical problems, pain, dother considerations, assessment/analysis of Italian and the could affect R9's cognitive take and non-licens resident and/or family interest and in the care area or R9, but did not indicate aled multiple pre-populate in the care area or R9, but did not indicate aled multiple pre-populates, which included: diseased ications and characteristic in impairment which requested the care area or R9, but did not indicate aled multiple pre-populates, which included: diseased ications and characteristic in impairment which requested the care area or R9, but did not indicate aled multiple pre-populates, which included: diseased ications and characteristic in impairment which requested the care area or R9, but did not indicate aled multiple pre-populates, which included: diseased ications and characteristic in impairment which requested the care area of R9, but did not indicate aled multiple pre-populates of R9's	g gered: ADL vioral re e care not ata stics, , R9's ed er ve sed put for a was e caed put for a was e caed put for	2 545			

Minnesota Department of Health

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2 545	Continued From pa	ge 4		2 545			
	communication. The other consideration communication from communication with staff members and care planning considerational/Reserve aled the care a R9, but did not indice multiple pre-popula which included possificating R9's functioning R9 was a decline. The CAA late possible ADL goals analysis of the afore checkmarks which functioning. The CAC considerations that functioning from reserved.	chabilitation Potential rea was an actual procate why. The CAA reted check marked are sible underlying problion, medications and trisk for because of facked ADL problem eand a comprehensivementioned pre-populimpacted R9's ADL AA further lacked any could affect R9's ADI	any 's n, ensed y input for  CAA bblem for evealed eas, ems functional valuation, e lated other				
	care planning consi	resident and/or family derations.	y input for				
	CAA revealed the c problem for R9, but CAA revealed multi marked areas which contributing to R9's diseases and condi CAA lacked a comp aforementioned pre- areas which impact CAA further lacked could affect R9's co- observation, comm	ce and Indwelling Catare area was an actual did not indicate why ple pre-populated check in included: modifiable urinary incontinence tions and medications and medications and prehensive analysis of e-populated check maked R9's incontinence any other consideration tinence from reside unication with license and resident and for face	al The eck e factors s. The f the arked . The tons that nt				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE S COMPL	
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2 545	Continued From pa	ige 5	2 545			
	input for care plann	ing considerations.				
	area was a potential indicate why. The Copre-populated check included: cognitive cause or exacerbate lacked a comprehe aforementioned preareas which impact further lacked any caffect R9's behavior communication with staff and resident a planning consideration.					
	problem for R9, but CAA revealed multi marked areas which performance limitated risk factors. The CA analysis of the afor check marked areas risk. The CAA furth considerations that risk from resident owith licensed and nand/or family input considerations.  -Nutritional Status (was a an actual profindicate why. The CA pre-populated check included: R9's functional problem medications. The CAA furth considerations.	d the care area was a potential tidd not indicate why. The ple pre-populated check h included: R9's physical tions, medications and internal AA lacked a comprehensive ementioned pre-populated as which impacted R9's fall er lacked any other could have affected R9's fall observation, communication on-licensed staff and resident for care planning  CAA revealed the care area oblem for R9, but did not CAA revealed multiple of the k marked areas which tional and mental status, s, disease conditions and CAA lacked a comprehensive ementioned pre-populated				

Minnesota Department of Health

STATE FORM SIKJ11 If continuation sheet 6 of 46

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
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2 545	check marked area nutritional risk. The considerations that nutritional risk from communication with staff and resident a planning consideration.  -Pressure Ulcer CA a potential problem why. The CAA reversheck marked area external risk factors that present complifor pressure ulcers comprehensive and pre-populated check impacted R9's risk further lacked any chave affected R9's resident observation licensed and non-licensed and non-licensed and non-licensed and non-licensed and anti-psychotic resident observations.  -Psychotropic Drug area was an actual indicate why. The Considerations for and adverse consecuted and anti-psychotic recomprehensive and pre-populated check impacted R9's risk medications. The Considerations that	s which impacted R9's CAA further lacked any could have affected R9 resident observation, a licensed and non-licen nd/or family input for cations.  A revealed the care are for R9, but did not indicated multiple pre-populas which included: interns, medications and conducations or increase R9's The CAA lacked a alysis of the aforementick marked areas which of pressure ulcers. The other considerations that risk of pressure ulcers for n, communication with censed staff and resider	's sed are sa was cate ated all and ditions is risk oned CAA t could from at care not sing, arug sant cked a oned other 's risk	2 545			

Minnesota Department of Health

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
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2 545	non-licensed staff a for care planning con R14 R14's Annual Minim 8/31/17, identified Fimpairment, had dia Cerebral Palsy and (GERD). The MDS extensive assistant dressing and hygien toileting and transfer had no natural teeth R14's Care Area As 8/31/17, identified effrom the data enternanalysis. The follow Cognitive Loss/Den Communication, Ur Indwelling Catheter Dental Care, Press Drug Use.  -Cognitive Loss/Den area was an actual cognitive loss and road cognitive loss and road revealed multimarked areas (from which included: obsand behavior, medi status and other con additional assessm cognition. The CAA analysis of the afore checkmarks which functioning. The CAA and Revenue Research Res	and resident and/or family input onsiderations.  The properties of the proposition of the	2 545			

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
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		00799	B. WING		03/2	9/2018
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HENNIN	G REHABILITATION &	HEALTHGARE G	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 545	-Visual Function CA an actual problem f why. The CAA reversed marked area MDS), which includ medications, require assessment/analys lacked a comprehe aforementioned presimpacted R14's visual lacked any other consideration, comminant-licensed staffing family input for care communication. The CAA reversed marked area and conditions, meaning the communication of the communication and the communication of the communication. The comprehensive and pre-populated check marked area and conditions of the communication. The comprehensive and pre-populated check marked area and conditions of the communication from communication from communication with staff members and care planning considerations.  -Urinary Incontinent	resident and/or family input for derations.  A revealed the care area was or R14, but did not indicate aled multiple pre-populated s (from data entered on the ed: disease conditions, and ing additional is of R14's cognition. The CAA insive analysis of the e-populated checkmarks which had function. The CAA further ensiderations that could affect ctioning from resident unication with licensed and nembers and resident and/or e planning considerations.  AA revealed the care area was or R14, but did not indicate aled multiple pre-populated s, which included: diseases dications and characteristics on impairment which required ent/analysis of R9's e CAA lacked a alysis of the aforementioned kmarks which impacted R14's e CAA further lacked any s that could affect R14's in resident observation, in licensed and non-licensed resident and/or family input for	2 545	DETICIENCT)		
	problem for R14, du	ue to frequent incontinence of d total dependence for				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  **STREET ADDRESS, CITY, STATE, ZIP CODE**  **907 MARSHALL AVENUE, PO BOX 57*  **HENNING, MN 56551*  **PREFIX TAG**  **STREET ADDRESS, CITY, STATE, ZIP CODE**  **907 MARSHALL AVENUE, PO BOX 57*  **HENNING, MN 56551*  **PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES THENNING, MN 56551*  **PREFIX TAG**  **STREET ADDRESS, CITY, STATE, ZIP CODE**  **907 MARSHALL AVENUE, PO BOX 57*  **HENNING, MN 56551*  **PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY STATE TO THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DEFICIENCY STATE TO THE APPROPRIATE DEFICIENCY STATE TO THE APPROPRIATE DEFICIENCY STATE TO THE APPROPRIATE DEFICIENCY STATE STATE TO THE APPROPRIATE DEFICIENCY STATE ST		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
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(24) ID PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 545  Continued From page 9 toileting The CAA revealed multiple pre-populated check marked areas which included: modifiable factors contributing to R14's incontinence. The CAA further lacked any other considerations that could affect R14's continence from resident observation, communications.  -Falls CAA revealed the care area was a potential problem for R14, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which impacted R14's physical performance limitations, medications and internal risk factors. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R14's fall risk. The CAA further lacked any other considerations that could affect R14's physical performance limitations, medications and internal risk factors. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R14's fall risk. The CAA further lacked any other considerations that could have affected R14's fall risk from resident observation, communication	NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  2 545  Continued From page 9  toileting The CAA revealed multiple pre-populated check marked areas which included: modifiable factors contributing to R14's incontinence, diseases and conditions and medications. The CAA further lacked any other considerations that could affect R14's continence from resident observation, communication with licensed and non-licensed staff and resident and /or family input for care planning considerations.  -Falls CAA revealed the care area was a potential problem for R14, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which impacted R14's physical performance limitations, medications and internal risk factors. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R14's fall risk. The CAA further lacked any other considerations that could have affected R14's fall risk from resident observation, communication				HENNING	, MN 56551			
toileting The CAA revealed multiple pre-populated check marked areas which included: modifiable factors contributing to R14's urinary incontinence, diseases and conditions and medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R14's incontinence. The CAA further lacked any other considerations that could affect R14's continence from resident observation, communication with licensed and non-licensed staff and resident and /or family input for care planning considerations.  -Falls CAA revealed the care area was a potential problem for R14, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: R14's physical performance limitations, medications and internal risk factors. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R14's fall risk. The CAA further lacked any other considerations that could have affected R14's fall risk from resident observation, communication	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE
and/or family input for care planning considerations.  -Nutritional Status CAA revealed the care area was a an actual problem for R14, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: R14's functional and mental status, behavioral problems, communication, disease conditions and medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R14's nutritional risk. The CAA further lacked any other considerations that could have	2 545	toileting The CAA pre-populated check included: modifiable urinary incontinence medications. The Canalysis of the afore check marked area incontinence. The Considerations that from resident observices and non-lie/or family input for considerations that from family input for considerations that from resident observices and non-lie/or family input for considerations. The CA analysis of the afore check marked areas whice performance limitated risk factors. The CA analysis of the afore check marked area risk. The CAA further considerations that risk from resident on with licensed and non-lied and/or family input considerations.  -Nutritional Status (was a an actual profindicate why. The CA pre-populated check included: R14's funbehavioral problem conditions and medicomprehensive and pre-populated check impacted R14's nutritional R	revealed multiple k marked areas whice factors contributing e, diseases and conc AA lacked a compre- ementioned pre-populate could affect R14's convation, communication care planning consider d the care area was a dut did not indicate who ple pre-populated che included: R14's phoions, medications and A lacked a comprehementioned pre-populated ementioned pre-populated che included: R14's phoions, medications and A lacked a comprehementioned pre-populated could have affected bservation, communication, communication, communication, communication, communication, discontinuous and mental sis, communicati	to R14's ditions and hensive ulated 14's ny other ontinence on with dent and erations.  a potential ny. The eck ysical internal itensive ulated 14's fall R14's fall ication is resident.  The area of not expected a no	2 545			

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
		00799	B. WING		03/	29/2018
NAME OF	PROVIDER OR SUPPLIER		ODRESS CITY S	STATE, ZIP CODE	03/	29/2010
		907 MAF		IUE, PO BOX 57		
HENNIN	G REHABILITATION 8	HENNING	G, MN 56551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 545	Continued From pa	age 10	2 545			
	non-licensed staff a for care planning co	nunication with licensed and and resident and/or family inpuonsiderations.	t			
	an actual problem to natural teeth, has used that he will wear as revealed multiple pareas which include functional problems	for R14, due to R14 has no upper and lower full dentures he chooses. The CAA re-populated check marked ed: R14's cognitive and s and disease conditions and				
	medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R14's dental risk. The CAA further lacked any other considerations that could have affected R14's dental risk from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations.					
	a potential problem why. The CAA rever check marked area external risk factors that present complifor pressure ulcers comprehensive and pre-populated check impacted R14's risl further lacked any chave affected R14's resident observation licensed and non-licensed and non-licensed and considerations.	, ,				
		Use CAA revealed the care problem for R14, but did not				

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00799	B. WING		03/2	9/2018
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HENNING	G REHABILITATION &	HEALINGARE G	HALL AVEN , MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 545	pre-populated check included: classes of treatable reasons for and adverse consect and anti-psychotic recomprehensive and pre-populated check impacted R14's risk medications. The Considerations that of using psychotropy observation, common-licensed staff of care planning considerations. The Considerations that of using psychotropy observation, common-licensed staff of care planning considerations. The Considerations of the pre-comprehensive assembly staff, in regards to the Assessments (CAA monitoring system) and share those recommittee for further considerations.	CAA revealed multiple ck marked areas which f medication R14 was taking, or use of psychotropic drug quences of anti-depressant medication. The CAA lacked a alysis of the aforementioned ck marked areas which c of using psychotropic CAA further lacked any other could have affected R14's risk oic medications from resident unication with licensed and and resident and/or family input onsiderations.  p.m. MDS coordinator she had completed R9 and C-A verified the CAAs lacked populated data and were not a	2 545			
2 685	MN Rule 4658.0469 and Death	5 Subp. 2 Transfer, Discharge,	2 685			5/4/18

6899

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00799	B. WING		03/2	9/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HENNIN	G REHABILITATION 8	HEALTHUARE (	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 685	transferred or disch than death, the nur discharge summary time of transfer or or discharge, transfer and condition.  This MN Requiremby: Based on interview facility failed to ensummary for 1 of 1 discharged to home Findings include:  Review of the Admindicated R24 was 12/13/17, with diag depression, diabeted Review of R24's Pt (PDS) listed R24's R24's medical reconditional rec	charge. When a resident is narged for any reason other sing home must compile a y that includes the date and discharge, reason for transfer fer or discharge diagnoses, ent is not met as evidenced and document review, the ure an accurate discharge resident (R24) who was a from the facility.	2 685	See State tag for Plan of Correction	on.	
	1/12/18 revealed th					

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00799	B. WING		03/	29/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
LIENNIN	G REHABILITATION &	HEALTHCARE C 907 MAR	SHALL AVEN	UE, PO BOX 57		
ПЕММИ	G REHABILITATION &	HENNIN	G, MN 56551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 685	Continued From page 13		2 685			
	significant other about discharge on 1/18/2 having the day off. home and lack of homedical doctor and health services (HE	•				
	-1/12/18 writer provided education to husband staff felt R24 was not quite ready to go home. Husband indicated R24 wanted to go home and he was going to take her home. R24 indicated she was feeling better now, had agreed to go see her primary medical doctor on 2/8/18, and information given to husband. Medications sent with R24, pharmacy notified, medical director aware. Skin upon discharge, psoriasis patches, red skin folds with powders applied. Discharged from facility with all medications and personal belongings with spouse.					
	R24 received continuous person-centered casummary did not in receive these service were contacted to eassist R24 in her house include any information occupational therapon home medicatio	been completed to ensure nuous and coordinated, are following discharge. The dicate if R24 was going to ces after discharge or if they ensure HHS would be able to ome. The summary did not ation from physical and by, did not include information as or what those medications what medications she was ing.				
	nursing (ADON) stanursing (DON) did in the completing discipled	p.m. assistant director of ated she felt the director of not know she was supposed to narge summaries and were a ADON indicated she felt R24				

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00799	B. WING		03/	29/2018
NAME OF	PROVIDER OR SUPPLIER	STREE	TADDRESS, CITY,	STATE, ZIP CODE		
HENNIN	G REHABILITATION &	HEALTHCARE C	ARSHALL AVEN ING, MN 56551	NUE, PO BOX 57		
(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 THE APPROPRIATE	(X5) COMPLETE DATE
2 685	was to receive hom services after disch setting the services indicated SS usuall they were discharge doing at home. ADO summaries were to resident was discharge summary not completed when facility. The DON in include discharge of medications, pharm equipment needed she just got a pile of week that went back indicated the facility person recently and charts to complete. Review of facility person recently and charts to complete. Review of facility person recently and charts to complete. Review of facility person recently and charts to complete. Such any special insphysician services in place to offer a complete of facility person recently and charts to complete. Such any special insphysician services in place to offer a complete of facility of designee could of the DON or designee could of the DON or designee.	e health services for theraparge and SS worked with up for the resident. She y called the residents once ed to check how they were DN indicated the discharge be completed after any arged from the facility.  p.m. DON confirmed a recapitulation on R24 discharged from the dicated the summary should reders, home health if needed at home. The DON indicated if discharges on her desk lack several months. The DON had a new medical recorded she was not bringing her to the discharge summaries.  Dicy titled, Discharging the 23/17, indicated the goal was ent was ready for their ext place. They will need if medications and treatment tructions as to therapy or they will need after discharge ave all supplies and service	vas d d d st l s e s			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00799	B. WING		03/2	9/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HENNING	G REHABILITATION &	HEALTHGARE G	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 685	report results to the for further recomme	quality assurance committee	2 685			
2 910	Subp. 5. Incontiner have a continuous property management to redunnecessary use of comprehensive reshome must ensure  A. a resident without an indwellin unless the resident' that catheterization  B. a resident where the receives appropriate prevent urinary trace	once. A nursing home must program of bowel and bladder luce incontinence and the catheters. Based on the ident assessment, a nursing that:  the enters a nursing home g catheter is not catheterized s clinical condition indicates was necessary; and the incontinent of bladder the treatment and services to the infections and to restore as the er function as possible.	2 910			5/4/18
	by: Based on observati review, the facility fa with toileting for 1 o toileting needs duri facility failed to prov	ent is not met as evidenced on, interview, and document ailed to provide assistance f 1 resident (R9) observed for ng the survey. In addition the vide appropriate catheter care ents reviewed with an		See State tag for Plan of Correction	on.	

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED	
00799				B. WING		03/	29/2018
NAME OF	PROVIDER OR SUPPLIER			, ,	STATE, ZIP CODE		
HENNIN	G REHABILITATION 8	HEALIHCAREC		SHALL AVEN , MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 910	R9's significant cha (MDS) dated 5/23/1 impairment and dia neurogenic bladder dementia, and anxi required supervisio and required extens and personal hygie R9's care plan revision physical functioning impairment, toiletin needed). Staff to he resistive to care and dementia, become allow nursing staff to incontinent. If residing living reassure 5-10 minutes later a with opportunities for provision. R9 had be intolerance, demen infection, physical liuse/side effects of Use of pull up disposite bathroom every perineal area with experimental experimental area with experimental e	ange Minimum Data Sel 17, identified severe coggnoses which included (bladder dysfunction) ety. The MDS indicated n with transfer and amberive assistance with toil ne.  Sed 9/16/17, revealed a gradient related to self congressistance of 1 PRN elp change and wash. Found toileting r/t (related to sessist him when he is the ent resists with activitie the resident, leave and related to rehoice during care of a pladder incontinence r/t tia, HX (history) of urinal imitations, poor toileting medication antidepressions and PRN. Observations and PRN. Observations on 3/28/18 observations of 3/28/18 observatio	gnitive d R9 bulation leting a care l (as R9 is d to) s to s sof eturn resident activity ary tract g habits, assist to Clean ode. EM)-A ere not M-A on an illity in 8, the	2 910			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED		
00799			B. WING 03/29			29/2018	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
			907 MAR	SHALL AVEN	UE, PO BOX 57		
HENNIN	G REHABILITATION 8	HEALTHCARE C		6, MN 56551	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 910		ige 17 mained seated in th	e chair	2 910			
		mained seated in the					
		tood and walked to t					
		y with his front whee					
		iry chair at a dining t					
	-At 8:28 a.m. R9 Remained seated in stationary chair in the dining room independently eatingAt 8:45 a.m. R9 stood from the dining table independently and returned to the brown leather stationary chair in the common area of the facility.						
	-At 9:02 a.m. R9 re		,				
	-At 9:11 a.m. R9 re						
	-At 9:21 a.m. R9 re						
	-At 9:23 a.m. R9 re -At 9:37 a.m. R9 re						
	-At 9:56 a.m. R9 re						
	-At 10:07 a.m. R9						
	-At 10:12 a.m. R9						
		stered nurse (RN)-B					
		ed with him briefly a					
		. R9 was observed v					
		in his pants, betwee B offered R9 to use	-				
		accepted. At that tim					
		ne bed until he had fi					
	eating a piece of ch						
		R9 had finished ea	•				
		om the bed, he point					
		nere do I go out there ing area in R9 's par					
		RN-B assisted R9 c					
		nall. RN-B had not a					
	cued R9 to use the						
		walked to the brown					
		n area and sat dowr					
		surveyor prompted s					
		NA-A walked with R					
		to go into the bathro ants and saturated i					
		the toilet and urinate					

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  907 MARSHALL AVENUE, PO BOX 57  HENNING REHABILITATION & HEALTHCARE C  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG CONSTRUCTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  (X5) ON 3/28/18, at 10:53 a.m. NA-A verified R9's incontinent product was soaked and hung down between his legs due to the weight of the saturation. NA-A indicated staff were to offer R9 assistance to toilet every two hours because he had short term memory loss.  On 3/28/18, at 11:06 a.m. NA-D stated although R9 was able to walk independently he required reminders for meals and physical assistance for dressing and toileting. NA-D stated staff offered R9 assistance for toileting every three to four hours.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
HENNING REHABILITATION & HEALTHCARE C    SUMMARY STATEMENT OF DEFICIENCIES   HENNING, MN 56551     (X4) ID   REFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   OTHER PROPRIATE DEFICIENCY			00799		B. WING		03/	29/2018
CAU   ID   PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES   ID   PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   DATE    2 910   Continued From page 18   2 910    Consider the completely saturated brief.   Consider the completely saturated brief.   Consider the completely saturated brief assistance to toilet every two hours because he had short term memory loss.   Consider the complete the com	NAME OF	NAME OF PROVIDER OR SUPPLIER STREET AL				STATE, ZIP CODE		
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  2 910  Continued From page 18 removed the completely saturated brief.  On 3/28/18, at 10:53 a.m. NA-A verified R9's incontinent product was soaked and hung down between his legs due to the weight of the saturation. NA-A indicated staff were to offer R9 assistance to toilet every two hours because he had short term memory loss.  On 3/28/18, at 11:06 a.m. NA-D stated although R9 was able to walk independently he required reminders for meals and physical assistance for dressing and toileting. NA-D stated staff offered R9 assistance for toileting every three to four	HENNIN	G REHABILITATION &	HEALINGAREG			IUE, PO BOX 57		
removed the completely saturated brief.  On 3/28/18, at 10:53 a.m. NA-A verified R9's incontinent product was soaked and hung down between his legs due to the weight of the saturation. NA-A indicated staff were to offer R9 assistance to toilet every two hours because he had short term memory loss.  On 3/28/18, at 11:06 a.m. NA-D stated although R9 was able to walk independently he required reminders for meals and physical assistance for dressing and toileting. NA-D stated staff offered R9 assistance for toileting every three to four	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FU		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE
On 3/28/18, at 1:29 p.m. NA-B identified R9 required staff assistance with toileting and were to check with R9 every two hours to assist with use of the toilet or to have his brief changed. NA-B indicated staff worked together as a team to care for all residents, however; stated she had not assisted R9 with toileting needs today.  On 3/28/18, at 1:39 p.m. RN-B indicated she was not aware R9 had not been toileted in a timely manor. RN-B indicated staff were expected to follow the care directed by the care plan for R9 who required staff assistance with toileting. RN-B identified timely toileting was important in order to keep R9 clean and dry and to prevent skin issues.  On 3/28/18, at 1:59 p.m. The director of nursing (DON) indicated toileting plans were developed for each resident by identifying the individual needs with a three day study of the residents bowel and bladder pattern. The DON verified staff	2 910	removed the comple on 3/28/18, at 10:5 incontinent product between his legs dusaturation. NA-A incassistance to toilet had short term men on 3/28/18, at 11:00 R9 was able to walk reminders for meals dressing and toiletir R9 assistance for to hours.  On 3/28/18, at 1:29 required staff assist to check with R9 evuse of the toilet or to NA-B indicated staff to care for all reside not assisted R9 with on 3/28/18, at 1:39 not aware R9 had manor. RN-B indicated follow the care direct who required staff a identified timely toile keep R9 clean and issues.  On 3/28/18, at 1:59 (DON) indicated toil for each resident by needs with a three of	etely saturated brief.  3 a.m. NA-A verified R was soaked and hung ue to the weight of the dicated staff were to off every two hours becaused in the same of the s	down fer R9 se he hough uired nce for ffered our  R9 were t with ed. team he had the was mely d to or R9 J. RN-B order to n ursing loped ual nts	2 910			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING.	<del></del>		
00799			B. WING		03/2	9/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HENNING	G REHABILITATION 8	E HEALTHGARE G	SHALL AVEN 5, MN 56551	IUE, PO BOX 57		
(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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 910	DON agreed three for R9 to not have I needs.  SUGGESTED MET The director of nurs develop, review, an procedures to ensuappropriate assiste The DON or design systems to ensure	and a half hours was too long been assisted with toileting  THODS OF CORRECTION: sing (DON) or designee could nd /or revise policies and ure resident received and toileting care and services. Hee could develop monitoring ongoing compliance.  R CORRECTION: Twenty-one	2 910			
2 915	Subp. 6. Activities comprehensive reshome must ensure A. a resident is treatments and ser abilities in activities deterioration is a not the resident's cond part, activities of daresident's ability to:  (1) bathe, dres (2) transfer an (3) use the toi (4) eat; and (5) use speece	s given the appropriate vices to maintain or improve s of daily living unless ormal or characteristic part of ition. For purposes of this aily living includes the ss, and groom; and ambulate;	2 915			5/4/18
	This MN Requirem	ent is not met as evidenced				

NAME OF PROVIDER OR SUPPLIER  HENNING REHABILITATION & HEALTHCARE C  (A) ID PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 915 Continued From page 20 by: Based on observation, interview, and document review, the facility failed to necessary services to maintain activities of daily living for 1 of 1 resident (R14) who required assistance with oral cares.  Findings include:  R14's quarterly Minimum Data Set (MDS) dated 2/19/18, identified R14 had severe cognitive impairment and had diagnoses which included Cerebral Palsy, Diabetes Mellitus and gastric esophageal reflux (GERD). The MDS identified R14 had no natural teeth, and required extensive assistance for bed mobility, locomotion, personal hygiene and dressing, total assistance for transfer and toilet use.  B14's Care Area Agrees ment (CAA) dated.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
HENNING REHABILITATION & HEALTHCARE C  907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  DEFICIENCY)  2 915  Continued From page 20  by: Based on observation, interview, and document review, the facility failed to necessary services to maintain activities of daily living for 1 of 1 resident (R14) who required assistance with oral cares.  Findings include:  R14's quarterly Minimum Data Set (MDS) dated 2/19/18, identified R14 had severe cognitive impairment and had diagnoses which included Cerebral Palsy, Diabetes Mellitus and gastric esophageal reflux (GERCH). The MDS identified R14 had no natural teeth, and required extensive assistance for bed mobility, locomotion, personal hygiene and dressing, total assistance for transfer and toilet use.	00799				B. WING 0:		
Cach Deficiency Must be preceded by Full Regulatory or Lisc identified assistance with oral cares.   Findings include:    R14's quarterly Minimum Data Set (MDS) dated 2/19/18, identified R14 had severe cognitive impairment and had diagnoses which included Cerebral Palsy, Diabetes Mellitus and gastric esophageal reflux (GERD). The MDS identified R14 had no natural teeth, and required extensive assistance for bed mobility, locomotion, personal hygiene and dressing, total assistance for transfer and toilet use.	NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  2 915  Continued From page 20 by: Based on observation, interview, and document review, the facility failed to necessary services to maintain activities of daily living for 1 of 1 resident (R14) who required assistance with oral cares.  Findings include:  R14's quarterly Minimum Data Set (MDS) dated 2/19/18, identified R14 had severe cognitive impairment and had diagnoses which included Cerebral Palsy, Diabetes Mellitus and gastric esophageal reflux (GERD). The MDS identified R14 had no natural teeth, and required extensive assistance for bed mobility, locomotion, personal hygiene and dressing, total assistance for transfer and toilet use.	HENNIN	G REHABILITATION &	HEALTHCARE C		·		
by: Based on observation, interview, and document review, the facility failed to necessary services to maintain activities of daily living for 1 of 1 resident (R14) who required assistance with oral cares.  Findings include:  R14's quarterly Minimum Data Set (MDS) dated 2/19/18, identified R14 had severe cognitive impairment and had diagnoses which included Cerebral Palsy, Diabetes Mellitus and gastric esophageal reflux (GERD). The MDS identified R14 had no natural teeth, and required extensive assistance for bed mobility, locomotion, personal hygiene and dressing, total assistance for transfer and toilet use.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	COMPLETE
R14's Care Area Assessment (CAA) dated 8/31/17, identified R14 cognitive loss, mental health diagnosis, had no natural teeth, had full upper and lower dentures that he wears as he chooses, no issues with dentures, no mouth concerns, staff to assist as needed. The CAA listed R14 had unstable diabetes related to oral infection and the overall objective was to maintain current level of functioning, avoid complications and minimize risks.  R14's care plan revised 9/5/17, identified R14 required assistance with activities of daily living and listed various interventions which included set up of oral care supplies, encourage and assist with oral cares twice a day and as needed. Further, the care plan listed to encourage R14 to wear dentures, use fixodent for fit, and would often refuse to wear dentures.  On 3/28/18, at 7:00 a.m. nursing assistant (NA)-A	2 915	by: Based on observatireview, the facility famaintain activities oresident (R14) who cares.  Findings include: R14's quarterly Mir 2/19/18, identified Fimpairment and had Cerebral Palsy, Dialesophageal reflux (R14 had no natural assistance for bed hygiene and dressinand toilet use. R14's Care Area As 8/31/17, identified Fhealth diagnosis, haupper and lower dechooses, no issues concerns, staff to a listed R14 had unst infection and the overcurrent level of fundand minimize risks. R14's care plan review required assistance and listed various is set up of oral care swith oral cares twice Further, the care plan wear dentures, use often refuse to wear	on, interview, and document ailed to necessary services to of daily living for 1 of 1 required assistance with oral minum Data Set (MDS) dated R14 had severe cognitive diagnoses which included betes Mellitus and gastric GERD). The MDS identified teeth, and required extensive mobility, locomotion, personaling, total assistance for transfers assessment (CAA) dated R14 cognitive loss, mental and no natural teeth, had full intures that he wears as he with dentures, no mouth sesist as needed. The CAA able diabetes related to oral verall objective was to maintain extioning, avoid complications dised 9/5/17, identified R14 with activities of daily living interventions which included supplies, encourage and assist a day and as needed. In listed to encourage R14 to fixodent for fit, and would relatives.	er n			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	, ,	E SURVEY PLETED
00799			B. WING	B. WING		
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
HENNIN	G REHABILITATION &	HEALINGARE G	RSHALL AVEN G, MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
2 915	and NA-D assisted NA-D obtained a babathroom while NA and placed gray sw NA-A and NA-D wo dress R14. R14 had a slightly sunke closed. At 7:14 a.m on a sling with a ful wheel chair. NA-D wash and dry his fa combed his hair, whater NA-D and NA NA-D placed the so separate opaque pl NA-D exited the roo NA-A stated they his bath and stated they his separate opaque pl NA-D exited the roo NA-A stated they his bath and stated they his separate opaque pl NA-D exited they his separate opaque pl NA-A stated they his separate opaque pl NA-D exited they his separate opaque pl NA-A stated they his separate opaque pl NA-D exited they his separate opaque pl NA-A stated they his separate opaque pl NA-D exited they his separate opaque pl NA-A stated they his separate opaque	ge 21 R14 with morning cares. asin of water in the adjoining -A applied R14's stockings eat pants on R14's lower legs rked together to wash and d no natural teeth, his mouth an appearance with his mouth R14 was lifted from the bed I body lift and seated in his continued to assist R14 to ce, neck, glasses and nile NA-A made R14's bedA completed R14's cares, siled linens and garbage into astic bags, and NA-A and om. At 7:21 a.m. NA-D and ad finished providing R14's he would be assisted to				
	On 3/29/18, at 1:13 p.m. NA-D confirmed she had not assisted R14 with oral cares on 3/28/18, and confirmed she had not offered him to wear his dentures. NA-D indicated the usual facility practice was to provide assistance with oral cares for dependent residents. She indicated she did not usually offer R14 his dentures because he did not wear them at times.		S			
	had not assisted R <sup>2</sup> She stated the usual residents with oral of	I p.m. NA-A confirmed she 14 with oral cares on 3/28/18. al facility practice was to assistances. NA-A stated she was ad dentures and did not offer the tures.	t			
	(DON) verified R14 the nursing assistar	p.m. the director of nursing 's current working care plan, nt care guide and R14's oral				

STATEMEN						(X3) DATE SURVEY COMPLETED	
	00799			B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
HENNING	G REHABILITATION &	HEALTHUARE (	SHALL AVEN , MN 56551	IUE, PO BOX 57			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTIES OF T	D BE	(X5) COMPLETE DATE	
2 915	Continued From pa	ge 22	2 915				
	evening, including r to be offered to swit (a dental sponge). expected staff to of care plan directed.  The facility policy tit 12/27/18, identified resident's lips and and freshen the resinfections of the months.						
	SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current ADL policies and procedures to ensure all residents receive ADL assistance as needed, and educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance.  TIME PERIOD FOR CORRECTION: Twenty-one						
	(21) days.						
21390	Subp. 4. Policies a control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans	O Subp. 4 A-I Infection Control and procedures. The infection ust include policies and provide for the following: based on systematic data y nosocomial infections in a detection, investigation, and so finfectious diseases; disprecautions systems to emission of infectious agents; ducation in infection trol;	21390			5/4/18	

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STATEMEN	AND DIAM OF CORRECTION INDENTIFICATION NUMBER				(X3) DATE	
00799			B. WING		03/2	9/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HENNIN	G REHABILITATION 8	HEALINGARE C	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	E. a resident he immunization progradefined in part 465 procedures of reside the prevention and F. the development of the prevention and F. the development of the prevention and F. the development of the procedures, including defined in part 4658 G. a system for the products which affed disinfectants, antissincontinence product of the products which affed disinfectants, antissincontinence product. In methods for the current standards of the program which including facility failed to imperiod the program. This had residents who residents include;  A review of the facility-wide system antibiotics including appropriate prescriity of antibiotic program also lacke and symptoms, laborated in the program also lacke and symptoms, laborated in the procedure of the program also lacke and symptoms, laborated in the procedure of the procedu	ealth program including an ram, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 8.0815; reviewing antibiotic use; review and evaluation of ect infection control, such as eptics, gloves, and cts; and maintaining awareness of of practice in infection control.  ent is not met as evidenced and document review, the lement an infection control uded a antibiotic stewardship to the potential to affect all 22	21390	See State tag for Plan of Correction	on.	

AND DIAN OF CORRECTION . IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		SURVEY PLETED		
			B. WING				
00799					03/2	29/2018	
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY,	,			
HENNIN	G REHABILITATION 8	HEALIHUAREU	ING, MN 56551	NUE, PO BOX 57			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
21390	Continued From pa	nge 24	21390				
	identified.						
	included the followi microbiology test re antibiotic order, sta number of days an start date to stop days	tled Essential Data, undated ng; date/resident, indication esults, type/route/frequency rt date, stop date, DOT (act tibiotic was used, should equate) infection surveillance o minimum criteria met (for ic use).	ıal				
	Review of the facility forms titled Essential Data revealed;						
	-November 2017, three residents were treated with antibiotics, for skin breakdown, cellulitis and C-Difficile (D-Diff). Two indicated no microbiology test results, and one indicated positive lab from hospital discharge. Antibiotics used were listed and symptoms were listed. Two indicated Loeb criteria met, and one indicated non applicable (N/A). The form lacked identification of pathogen, sensitivity reports and analysis of data.						
	antibiotics, two for two for urinary tract prophylactic use or positive lab results admission. Antibio entries indicated Natwo indicated they	six residents listed to use pneumonia, one for C-Diff, t infection (UTI) and one for admission. Two indicated and four indicated N/A on tics used were listed. Four /A for Loeb criteria met, and did not. The form lacked hogen, sensitivity reports ar	d				
	cellulitis. The form symptoms, and ind criteria was not me	e resident listed as treated f listed antibiotic use and icated the Loeb minimum t. The form lacked hogen, sensitivity reports ar					

Minnesota Department of Health

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00799	B. WING		03/2	9/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HENNIN	G REHABILITATION &	HEALTHCARE C	SHALL AVEN 6, MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	treated for UTI and indicated Klebsiella pseudomonas aure test results, and indicated results, and indicated results, and indicated as previous program, and had tinfection control nursing staff we without reviewing it confirmed the antibnot fully functioning.  During interview on registered nurse (R facility infection preshe had just begun program, and had tinfection control nursing regarding criteria begindicated this was rindicated some of the alternative treatmental were on board your consistently obtained.	o residents were listed as respiratory. The form pneumoniae and oginosa for UTI microbiology licated it met the Loeb's The respiratory was eumonia on admission and y test results. The form eport and analysis of data.  The was provided.  The port and analysis of data.  The was provided.  The port and analysis of data.  The was provided.  The port and analysis of data.  The was provided.  The was provided the or position and had trained at the beginning of March, are not to start an antibiotic with RN-C first. DON iotic stewardship program was		DEFICIENCY		
	the program was st					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00799	B. WING		03/2	9/2018
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HENNING	G REHABILITATION 8	CHEALINGARE C	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21390	Continued From pa	age 26	21390			
	Program, undated, antibiotic stewardsl leadership commitr expertise, action, tr education. The antincluded the medical	tled Anti-microbial Stewardship listed the core elements of the hip program which included; ment, accountability, drug racking, reporting and tibiotic stewardship team al director, consulting or of nursing and infection				
	The DON or infection policies and processurveillance prograstewardship. The D	THOD OF CORRECTION: on preventionist could develop dures for the infection control on to include antibiotic DON or infection preventionist itoring systems to ensure e.				
	TIME OF CORREC	CTION: Twenty One days (21)				
21525	MN Rule 4658.1309 Consultation	5 A.B.C Pharmacist Service	21525			5/4/18
	services of a pharm Board of Pharmacy A. provides con provision of pharma home; B. establishes and disposition of a detail to enable an C. determines	a system of records of receipt all controlled drugs in sufficient accurate reconciliation; and that drug records are and that an account of all				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00799		B. WING		03/	29/2018
	PROVIDER OR SUPPLIER  G REHABILITATION 8	HEALTHCARE C	907 MARS		STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM.	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21525	Continued From pa	ige 27		21525			
	by: Based on observat review, the facility f accurate accountin	ent is not met as evion, interview, and defailed to ensure a system of medications in fixed to prevent poten	ocument stem for 1 of 1		See State tag for Plan of Cor	rection.	
	Findings include:						
	On 3/27/18 at 2:52 p.m. a medication storage room tour was conducted with registered nurse (RN)-A. Located in a cupboard above the sink area was a gray metal box which was identified by RN-A as the facility emergency stock medication box A (E-Kit). The gray metal box was secured with a white plastic strip/lock attached to the clasp of the box. The white plastic strip had the number 0037535 on the tab of the strip.						
	for Security Tag Nu Medication Monitor entry was dated 7/1 ring notebook the fataken out of the E-I-Doxycycline 100 m tablets was taken a replaced with the n match the current sthe E-Kit. No further egarding the replaced in the E-Kit was found in the state of the s		st recent untitled 3 medication /18, five d been ich did not tached to s found of the				
	and called the phar had been switched	confirmed the above macy to see when the out. The pharmacy eplaced on 3/23/18. I	ne E-Kit indicated				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00799	B. WING		03/2	9/2018
	PROVIDER OR SUPPLIER  G REHABILITATION 8	HEALTHCARE C 907 MARS	SHALL AVEN	STATE, ZIP CODE		
		HENNING	, MN 56551			
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21525	Continued From page 28		21525			
	indicated the facility when pharmacy sw was aware of. RN-A E-Kits numbers in t for along time.	or did not log the strips/lock itched the E-Kits out, that she A indicated they used to log the he past but had not done this				
	(CP) indicated he the out with E-Kit B on the E-Kits were broopen the cupboard, cupboard and take the pharmacy. The not track anything were suited to the contract the contract that the contract the contract that the contract tha	p.m. consulting pharmacist hought E-Kit A was switched 3/15/18. PTD indicated when ught over to the facility, they put the new E-Kit in the the old one with them back to CP indicated the facility did when switching out the E-Kits hy of strips/locks at all.				
	(DON) confirmed the indicated the facility strips/locks since 2 DON verified the st E-Kits were switched stopped doing strips/locks needed drug diversion and	p.m. director of nursing ne above findings and had not tracked the 016, almost 2 years ago. The rips were not tracked when the ed out and indicated the facility it. The DON indicated the to be tracked due to potential indicated it was the facilities ke sure the locks were being				
	Reconciliation date facilty will documen booklet to confirm t addition when the bwill confirm the ider facility log. Further	by policy titled, Medications d "12/27/18", identified the at the identification number in a the E-Kit was locked. In lock is relocked the pharmacy nitification number matches the policy listed the facility kit contents annually in QAPI ncillation errors.				
	SUGGESTED MET	HOD OF CORRECTION:				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00799		B. WING		03/2	29/2018	
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE			
HENNIN	G REHABILITATION &	HEALTHCARE C		, MN 56551	IUE, PU BOX 57			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
21525	The director of nurs	ge 29 sing (DON) and the Co stablish a system for		21525				
	accurate accounting emergency kits to p diversion. The DO	g of medications in the prevent potential loss N could randomly aud audits to the quality as	e or lit the					
	TIME PERIOD OF (14) days.	CORRECTION: Four	teen					
21530	A. The drug regim reviewed at least mourrently licensed by This review must be Appendix N of the Surveyor Procedure Requirements in Lot the Department of Health Care Finance This standard is invavailable through the system. It is not sure B. The pharma irregularities to the and the attending processing must be acted upor physician visit, or so pharmacist. For purpon' means the acreport and the significant of nursing services C. If the attend with the pharmacist not provide adequation pharmacist believes	en of each resident monthly by a pharmacis y the Board of Pharm e done in accordance State Operations Manies for Pharmaceutical ong-Term Care, publishealth and Human Seing Administration, Appropriated by reference Minitex interlibrary bject to frequent chancist must report any director of nursing sere hysician, and these residents part, "a cceptance or rejectioning or initialing by the and the attending physician does not be justification, and the sthe resident's quality ected, the pharmacist	ust be st acy. with ual, Service shed by rvices, oril 1992. ce. It is loan ge. vices eports xt he cted of the director rsician. t concur r does e of life is	21530			5/4/18	

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00799	B. WING		03/2	9/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HENNIN	G REHABILITATION &	HEALINGARE C	SHALL AVEN	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21530	refer the matter to tif the medical direct physician. If the me the attending physic justification for the ophysician does not must be referred for assessment and as by part 4658.0070. The medical director must refer the matter assessment and as a sessment and as	he medical director for review for is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter review to the quality surance committee required. If the attending physician is or, the consulting pharmacist er directly to the quality surance committee.  The attending physician is or, the consulting pharmacist er directly to the quality surance committee.  The attending physician is or, the consulting pharmacist er directly to the quality surance committee.  The attending physician is or, the consulting pharmacist er directly to the quality surance committee.  The attending physician is or, the consulting pharmacist er directly to the quality surance committee.  The attending physician is or, the consulting (ADL) reviewed edications.  The attending physician is or, the consulting (ADL) such as, supervision and eating, and required the gradient end at the personal hygiene. The shad hallucinations, behavioral of the use of a daily cation and a daily cation and a daily	21530	See State tag for Plan of Correction	on.	

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00799	B. WING		03/2	29/2018
NAME OF	PROVIDER OR SUPPLIER	•	DDRESS, CITY, S	STATE, ZIP CODE		0.2010
HENNIN	G REHABILITATION 8	CHEALINGARE C	SHALL AVEN 3, MN 56551	NUE, PO BOX 57		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21530	Continued From pa	age 31	21530			
	6/22/17, identified of Parkinson's diseas problems, but did no potential problem. In pre-populated data received anti-psychhallucinations, how or complete an anamedication, or hallured and the received anti-psychoehavior managem R15's care plan list included: administed ordered by physicial effectiveness, consphysician to considict clinically appropriate behaviors/intervent attempted and their policy, educate abomonitor/document/ of psychotropic melacked identification non-pharmacologic behaviors.  R15's signed Physicial evening for Lewy Bedementia with behar 9/6/17 and Seroquel evening for Lewy Bedementia relabelavioral disturbations.	vised on 3/25/18, indicated R15 notic medication related to hent and disease process. Led various interventions which er psychotropic medications as an, monitor for side effects and sult with pharmacy and her dosage reduction when the at least quarterly, review cions and alternate therapies of effectiveness as per facility but risks and benefits and report any adverse reactions dications. R15's care plan of targeted behaviors and cal interventions to use for the dician Orders dated 1/30/18, 12.5 milligram (mg) in the cody dementia related to avioral disturbance, ordered on el 25 mg at bedtime Lewy ated to dementia with ince, ordered on 9/6/17.				
		onthly electronic medication ord (EMAR) and electronic				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00799	B. WING		03/	29/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
HENNIN	G REHABILITATION &	HEALIHCAREC	SHALL AVEN G, MN 56551	UE, PO BOX 57		
(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	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21530	treatment administr January 2018, to M received Seroquel to 8:00 p.m. and antigeffect monitoring east EMAR and ETAR's identification for Se A request for behavior placed, however the any monitoring for M On 3/27/18, at 3:30 arm chair in the day down with chin tuck had clear drainage approached R15 ar thanked staff meml 3:53 p.m. R15 remains head down and On 3/28/18, at 7:01 room after complete (NA)-B assisted R1 bath chair. R15 was wear and was able from NA-B.  On 3/28/18, at 7:49 able to follow simplification activities of daily living behaviors, was present the size of the size of the size of the walked to an arm country at 10:12 a.m. R15 was activitied and then walked to an arm country at 10:12 a.m. R15 was activitied and then walked to an arm country at 10:12 a.m. R15 was activitied as a many country at 10:12 a.m. R15 was activitied and then walked to an arm country at 10:12 a.m. R15 was activitied and then walked to an arm country at 10:12 a.m. R15 was activitied and then walked to an arm country at 10:12 a.m. R15 was activitied and then walked to an arm country at 10:12 a.m. R15 was activitied and then walked to an arm country at 10:12 a.m. R15 was activitied and then walked to an arm country at 10:12 a.m. R15 was activitied and then walked to an arm country at 10:12 a.m. R15 was activitied and the walked to an arm country at 10:12 a.m. R15 was activitied and the walked to an arm country at 10:12 a.m. R15 was activitied and the walked to an arm country at 10:12 a.m. R15 was activitied and the walked to an arm country at 10:12 a.m. R15 was activitied and the walked to an arm country at 10:12 a.m. R15 was activitied and the walked to an arm country at 10:12 a.m. R15 was activitied and the walked to an arm country at 10:12 a.m. R15 was activitied and the walked to an arm country at 10:12 a.m. R15 was activitied at	ration record (ETAR) from arch 2018, revealed R15 wice daily, at 4:00 p.m. and osychotic medication side ach shift. However, R15's lacked target behavior roquel use.				

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Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00799	B. WING		03/	29/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
HENNIN	G REHABILITATION &	HEALIHCARE C	SHALL AVEN G, MN 56551	UE, PO BOX 57		
(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 ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21530	chest.  On 3/29/18, at 3:32 arm chair in the day down and chin was seated quietly with a seated quietly with a stated R15 received behaviors and indic wandering. RN-A st mannerisms than b On 3/29/18, at 3:44 with his head down NA-C stated R15 di wandering a little, b On 3/29/18, at 3:55 nursing (ADON) stated R15 had no behavior orders or the care p R15 had no behavior orders or the care p R15 had no behavior orders or the care p R15 had no behavior orders or the care p R15 had no behavior orders and then SSD confirmed R15 behaviors and then SSD confirmed R15 behavior monitoring really have behavior was easily redirected On 3/29/18, at 4:12 (DON) stated R15's psychosis related to stated R15's care p	p.m. R15 was seated in an y room. R15's head was bent tucked to chest. R15 was a visitor seated to the left.  p.m. registered nurse (RN)-Ad Seroquel for dementia with ated the target behavior was ated R15 had more ehaviors.  p.m. NA-C stated R15 walked and would walk into things. splayed a behavior of ut was redirectable.  p.m. assistant director of ated R15 had no targeted quel identified on the physician olan. The ADON confirmed or monitoring.  p.m. social services designee cility's normal practice for ehaviors was to place them on R. SSD stated she would not progress notes for update providers as needed. 5's EMAR lacked target g. SSD stated R15 does not rs, except wandering and R15				

Minnesota Department of Health

STATE FORM SIKJ11 If continuation sheet 34 of 46

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00799		B. WING		03/2	29/2018
NAME OF	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HENNIN	G REHABILITATION &	HEALTHCARE C		SHALL AVEN , MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21530	expect them to be of staff knew what to remain the medications. Nursir expect them to be of staff knew what to remain the medications. The daily monitoring for anti-psychotic medical of the medication of the medications of the medication regimers. The medication regimers of the medication of the medication of the medication regimers of the medication of the medications. The medications of the medicati	on R15's care plan, somonitor. DON reviewed it lacked monitorin DON stated she wouthe indicated use of cation.  p.m. advanced prace PRN) stated R15's Sychosis related to Levated R15's target belanguard properties are portional points and practice of the CP nt's medical chart for a review on a monthlogularity was found, a could be made. CP stated R15's Seroquel was related to Lewy Before felt would not need R15's Seroquel was related to Lewy Before felt would not need R15's Seroquel was related to Lewy Before felt would not need R15's CP stated the facility of the CP sta	red R15's ag for ld expect an tice leroquel wy Body havior ald expect don R15 is visit.  rmacist was to a y basis.  ated for g for ntial as ody leed target ty would le was l.  TION: The land revise of target cated as	21530			

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00799	B. WING		03/2	9/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
HENNIN	G REHABILITATION 8	HEALINGARE C	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21530	target behaviors. The with the pharmacist reviews on a regula	ge 35 ne DON or designee, along t, could audit medication basis to ensure compliance. R CORRECTION: Twenty one	21530			
21685	Subp. 2. Physical pincluding walls, floor systems, and equip continuous state of with regard to the hwell-being of the regroutine maintenance.  This MN Requirements was assed on observative review, the facility fice machine to prevall 22 residents (R1 R9, R10, R11, R12 R18, R19, R21, R2 in the facility.  Findings include:  On 3/26/18, at 12:3 the facility, a water main dining room of have a crusted hard under the ice and walso noted to have and heavy hard war	Subp. 2 Plant eration, & Maintenance plant. The physical plant, was, ceilings, all furnishings, whent must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program.  The program are a evidenced on, interview and document ailed to maintain the water and went potential contamination for R2, R3, R4, R5, R6, R7, R8, R13, R14, R15, R16, R17, R12, R124) who currently resided a p.m. during an initial tour of and ice machine located in the fifthe facility, was observed to dispenser. The tray was light water lime scale build up the lime scale running around the of the machine. The	21685	See State tag for Plan of Correction	on.	5/4/18

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		, ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY
				B WINC			
		00799		B. WING		03/2	29/2018
NAME OF	PROVIDER OR SUPPLIER			, ,	STATE, ZIP CODE		
HENNIN	G REHABILITATION 8	HEALTHCARE C		MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21685	resident refrigerator room was observed lime scale build up dispenser and the the light water lime scale on 3/27/18, at 1:00 was conducted with The following concerthe water and ice in dining room of the encrusted hard water do noted to have light heavy hard water lime outer edge of indicated the water and had just gotten white lime scale that the ice and water do the staff cleaned the everyday but felt the under the ice and water do the staff cleaned the veryday but felt the under the ice and water do the staff cleaned the everyday but felt the under the ice and water dispenser and the the light water lime scale but dispenser and the the light water lime scale but dispenser and ice from building. The DM veresident three times meal and indicated machines were that On 3/27/18 at 1:24	r located in the north famed to have encrusted hard under the ice and water tray was also noted to have le build up on it.  7 p.m. a tour of the kitches in the dietary manager (Dietars were identified: machine located in the machine located in the machine scale build up unispenser. The tray was a water lime scale build up me scale running around and ice machine. The DM and ice machine had a left could be chipped off ur ispenser. The DM indicate ice and water machine e staff did not think to cleavater dispenser.  The DM indicate e ice and water dispenser.  The DM indicate the resident water dispenser.  The DM indicate the ice and water dispenser.  The DM indicated the resident both locations within the perified staff pass water to sa day in rooms, at every she did not realize the ice to "bad" with buildup.  The DM indicated the resident both locations within the perified staff pass water to sa day in rooms, at every she did not realize the ice to "bad" with buildup.	water ve en M), ain der lso and the eak kes of nder ted ean h urd water ve s get s get	21685			
	both locations three	s water to the residents f e times a day for water in ed the above findings.					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00799	B. WING		03/2	9/2018
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HENNING	G REHABILITATION 8	CHEALIHUARE U	HALL AVEN , MN 56551	IUE, PO BOX 57		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21685	Continued From pa	age 37	21685			
	Cleaning Policy, creensure ice machine germs from day to machine operating machines outside, cleaned daily, and should be done ins					
	director of the dieta develop, review, an procedures to ensu- were maintained in infection control pra	THOD OF CORRECTION: The ary manager or designee could and /or revise policies and ure water and ice machines accordance to acceptable actices. The dietary manager develop monitoring systems to mpliance.				
	TIME PERIOD FOI (14) days.	R CORRECTION: Fourteen				
21880	MN St. Statute 144 Residents of HC Fa	.651 Subd. 20 Patients & ac.Bill of Rights	21880			5/4/18
	shall be encourage their stay in a facilit to understand and patients, residents, residents, residents may voice changes in policies and others of their interference, coerc including threat of grievance procedurates and addresses and statement of the procedurates of the procedurates and their statement of the procedurates and the proc	nces. Patients and residents and and assisted, throughout by or their course of treatment, exercise their rights as and citizens. Patients and e grievances and recommend and services to facility staff choice, free from restraint, ion, discrimination, or reprisal, discharge. Notice of the re of the facility or program, as and telephone numbers for the acility Complaints and the area				

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00799	B. WING		03/2	9/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HENNIN	G REHABILITATION 8	HEALTHCARE C	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21880	nursing home ombour Americans Act, second posted in a conspication of the posted in the po	udsman pursuant to the Older tion 307(a)(12) shall be	21880			
	by: Based on observative review the facility fa	ent is not met as evidenced ion, interview and record ailed to perform dignified cares (R1) observed during catheter ares.		See State tag for Plan of Correction	on.	
	Findings include:					
	R1's quarterly Minir	num Data Set (MDS)				

MANE OF PROVIDER OR SUPPLIER  HENNING REHABILITATION & HEALTHCARE C  907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 66551  (X04) ID (EACH DEPICIEON/USITS EP RECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21880  Continued From page 39  assessment, dated 12/23/17, identified diagnoses which included cerebral vascular accident (CVA), diabetes mellitus and obstructive uropathy. R1 was cognitively intect and required extensive assistance with bed mobility, dressing and hygiene. R1:s MDS further the aga and tubing below the level of the bladder and away from entrance room door. R1's care plan further identified R1 had tested positive for C-Diff (clostridium difficile; bacterial infection with symptoms of watery diarrhea) and R1 was on contact precautions.  The facility nursing assistant care sheet, untitled, undated, indicated R1 was on contact precautions.  The facility nursing assistant care sheet, untitled, undated, indicated R1 was on contact precautions.  The facility nursing assistant care sheet, untitled, undated, indicated R1 was on contact precautions.  The facility nursing assistant care sheet, untitled, undated, indicated R1 was on contact precautions for C-Diff and was incontinent of bowel. The care sheet also identified R1 had a foley catheter.  On 3/27/18, at 8.33 a.m. R1 was lying on back on his bed. R1's catheter bag was attached to the bed frame, uncovered. A moderate amount of dark amber urine was present in the bag and was visible from the hall, while R1's room door was opened wide to the hall.  On 3/28/18, at 9.34 a.m. R1 was observed lying on his back in bed, with R1's catheter bag was visible through the door from the hallway. R1's catheter bag was uncovered, the bottom 1/3 of the bag was rested directly on the floor.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
SUMMARY STATEMENT OF DEFICIENCIES   TAG			00799		B. WING		03/	29/2018
CALL   CALL	NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PREFIX TAG  REGULATORY OR ISC IDENTIFYING INFORMATION)  21880  Continued From page 39  assessment, dated 12/23/17, identified diagnoses which included cerebral vascular accident (CVA), diabetes mellitus and obstructive uropathy. R1 was cognitively intact and required extensive assistance with bed mobility, dressing and hygiene. R1's MDS further identified R1 utilized an indwelling catheter.  R1's care plan, updated 3/24/18, indicated R1 used an indwelling catheter.  R1's care plan, updated 3/24/18, indicated R1 would be free from catheter-related trauma and directed staff to position catheter bag and tubing below the level of the bladder and away from entrance room door. R1's care plan further identified R1 had a foley catheter.  The facility nursing assistant care sheet, untitled, undated, indicated R1 was on contact precautions for C-Diff and selection with symptoms of watery diarrhea) and R1 was on contact precautions for C-Diff and so incontinent of bowel. The care sheet also identified R1 had a foley catheter.  On 3/27/18, at 8:33 a.m. R1 was lying on back on his bed. R1's catheter bag was attached to the bed frame, uncovered. A moderate amount of dark amber urine was present in the bag and was visible from the hall, while R1's room door was opened wide to the hall.  On 3/28/18, at 9:34 a.m. R1 was observed lying on his back in bed, with R1's catheter bag was visible through the door from the hallway. R1's catheter bag was uncovered, the bottom 1/3 of	HENNIN	G REHABILITATION &	HEALTHCARE C			UE, PO BOX 57		
assessment, dated 12/23/17, identified diagnoses which included cerebral vascular accident (CVA), diabetes mellitus and obstructive uropathy. R1 was cognitively intact and required extensive assistance with bed mobility, dressing and hygiene. R1's MDS further identified R1 utilized an indwelling catheter.  R1's care plan, updated 3/24/18, indicated R1 used an indwelling catheter related to a neurogenic bladder. The care plan indicated R1 would be free from catheter-related trauma and directed staff to position catheter bag and tubing below the level of the bladder and away from entrance room door. R1's care plan further identified R1 had tested positive for C-Diff (clostridium difficile; bacterial infection with symptoms of watery diarrhea) and R1 was on contact precautions.  The facility nursing assistant care sheet, untitled, undated, indicated R1 was on contact precautions for C-Diff and was incontinent of bowel. The care sheet also identified R1 had a foley catheter.  On 3/27/18, at 8:33 a.m. R1 was lying on back on his bed. R1's catheter bag was attached to the bed frame, uncovered. A moderate amount of dark amber urine was present in the bag and was visible from the hall, while R1's room door was opened wide to the hall.  On 3/28/18, at 9:34 a.m. R1 was observed lying on his back in bed, with R1's catheter bag was visible through the door from the hallway. R1's catheter bag was uncovered, the bottom 1/3 of	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE
On 3/28/18, at 10:16 a.m. R1 remained on his	21880	assessment, dated diagnoses which in accident (CVA), dia uropathy. R1 was extensive assistance and hygiene. R1's utilized an indwelling neurogenic bladder would be free from directed staff to postelow the level of the entrance room door identified R1 had te (clostridium difficile symptoms of water contact precautions.  The facility nursing undated, indicated precautions for C-D bowel. The care sholey catheter.  On 3/27/18, at 8:33 his bed. R1's catheter bad was unthe bad was rested.	12/23/17, identified cluded cerebral vasc betes mellitus and o cognitively intact and se with bed mobility, MDS further identified g catheter.  ated 3/24/18, indicate catheter related to a catheter related transition catheter bag and e bladder and awayer. R1's care plan further bacted positive for C-D; bacterial infection via diarrhea) and R1 with and was incontined a.m. R1 was incontined a.m. R1 was lying of eter bag was attached at a moderate amount as present in the bacterial infection with R1's catheter bacted. A moderate amount as present in the bacted at a moderate amount and the later and t	cular bstructive d required dressing ed R1  ced R1  cated R1 ma and nd tubing from ther oiff vith vas on  c, untitled, ent of 1 had a  on back on d to the ount of g and was or was  ved lying bag was y, R1's m 1/3 of	21880			

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Minneso	ota Department of He	alth				
STATEMEN			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00799	B. WING		03/2	9/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HENNIN	G REHABILITATION &	HEALINGARE C	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(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 APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21880	Continued From pa	ge 40	21880			
	back in his bed, cover catheter tubing was his blanket, down to unhooked from the directly on the floor resting on the floor perineal a large amount of the dead assisted R1 to his lead to be and the brief. The brief had loose stool, visible to the brief. NA-E han moved it over R1's garbage can, locate the floor next to the used several dispose perineal area, butto brown stool. Each handed the soiled wit below R1's face in observed multiple to and wipes, then loo Registered nurse (If supply of additional to NA-E and NA-B, incontinence care, perineal area and the wipes over to NA-B directly below R1's they assisted him to On 3/29/18, at 3:34 was not good to har products placed close	vered with linens. His sobserved running from under to the catheter bag, which was bed, uncovered and rested with the lower 1/3 of the bag NA-B and NA-E entered his catheter bag, then proceeded cares. R1 was incontinent of lark brown loose stool, which is thighs, the cloth incontinence his sheet. A tan, plastic bserved on each side of R1's of the bed. NA-E and NA-B eft side then removed his a large amount of brown, on the inside and outside of ded the dirty brief to NA-B who head and placed it in the ed directly below R1's face, on eleft side of his bed. NA-E sable wipes to cleanse R1's ecks and thighs of the dark time she used a wipe, she wipe to NA-B, who then placed in the garbage can. R1 was imes looking at the soiled brief				

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AND DIAN OF CORRECTION TO TRENTIFICATION NUMBERS		` ′	E CONSTRUCTION		SURVEY PLETED		
		00799		B. WING		03/	29/2018
NAME OF	PROVIDER OR SUPPLIER	00733	STREET AD	DRESS CITY S	STATE, ZIP CODE	03//	29/2010
					IUE, PO BOX 57		
HENNIN	G REHABILITATION 8	R HEALTHCARE C		, MN 56551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21880	Continued From pa	age 41		21880			
	preferred staff to us	se the garbage can c ed, not the one in fror					
	noticed the placem she completed R1's confirmed she had the soiled brief and confirmed the soile placed in front of R NA-B indicated she handling of the soil indicated she had thappy if someone had the soil thappy if someone had the soil thappy if someone had the soil thappy if someone had so indicated she had the soil that she had the she had th	op.m. NA-B indicate ent of the garbage cast incontinence cares to reach over R1's has soiled wipes during debrief and soiled wipes during a later talked to R1 all ed products and wipes old him she would not need treated her grand cologized. NA-B indicates a later was unloor.	an after . NA-B ead with cares and bes were ge can. bout the es, ot of been dparent in cated she				
	On 3/28/18, at 2:17 p.m. NA-E indicated when she entered the room she had not noticed the catheter bag was on the floor, but felt it may have slipped out the cloth bag. NA-E stated she was aware there were two garbage cans in R1's room, but indicated she had handed the used items soiled, with brown loose stool, to NA-B because the garbage can on R1's right side did not have a new liner in it. She indicated she did not even think of the position of the garbage can during R1's incontinence cares. NA-E confirmed it was a concern to hand the soiled brief and soiled wipes over R1 and place them into the garbage can directly in front of his face.  On 3/29/18, at 1:08 p.m. director of nursing (DON) indicated R1's catheter bag should be covered with a cloth bag at all times, and had been aware R1's catheter bag had been uncovered in the past. DON indicated R1						

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00799	B. WING		03/2	9/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
HENNING	G REHABILITATION &	HEALTH(CARE (C	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21880	only for his dignity, the facility. DON in nursing staff to han appropriately, plan supplies/equipment she felt placing soi residents face durir dignified care.	needed to be covered, not but for residents and visitors in dicated she would expect	21880			
	dated 12/27/17, ind treated with dignity meaning resident w maintaining and en and self-worth. Den standards of care the prohibited. The poli	icated all residents shall be and respect at all times,				
	Director of Nursing and revise policies educate staff on the	THOD OF CORRECTION: The and/or designee could review pertaining to resident rights, ese policies and perform ch resident's rights have been				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
21925	MN St. Statute 144 Residents of HC Fa	.651 Subd. 29 Patients & ac.Bill of Rights	21925			5/4/18
	shall not be arbitrar Residents must be proposed discharge	ers and discharges. Residents ily transferred or discharged. notified, in writing, of the e or transfer and its than 30 days before				

NAME OF PROVIDER OR SUPPLIER  HENNING REHABILITATION & HEALTHCARE C    C(A4) ID   PREFTX   SUMMARY STATEMENT OF DEFICIENCIES   97 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551    C(A4) ID   PREFTX   REACH TORRICO THAN 18 THE PROCESSED BY TALL   PROVIDERS PLAN OF CORRECTION SHOULD BE RECEDED BY TALL   PREFTX   PROVIDERS PLAN OF CORRECTION SHOULD BE RECEDED BY TALL   PREFTX   PROVIDERS PLAN OF CORRECTION SHOULD BE RECEDED BY TALL   PREFTX   PROVIDERS PLAN OF CORRECTION SHOULD BE RECEDED BY TALL   PREFTX   PREFTX   PROVIDERS PLAN OF CORRECTION SHOULD BE REACH CORRECTIVE ACTION SHOULD BE RECEDED BY TALL   PREFTX   PROVIDERS PLAN OF CORRECTION SHOULD BE REACH CORRECTIVE ACTION SHOULD BE REACH CORRECTION. THE REACH CORRECTIVE ACTION SHOULD BE REACH CORRECTION. THE REACH CORRECTION SHOULD BE REACH CORRECTION. THE REACH CORRECTION SHOULD BE REACH CORRECTION. THE REACH CORRECTION SHOULD BE REACH CORRECTION. THE REACH COR	AND DUAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  (X3)			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  HENNING REHABILITATION & HEALTHCARE C    C(X)   D   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   (FACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   FACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   FACH DEFICIENCY MUST BE PRECEDED BY FULL   PROVIDER'S PLAN OF CORRECTION   COMPLETE   PROVIDER'S PLAN OF CORRECTION   PREFIX   FACH DEFICIENCY   PREFIX   PROVIDER'S PLAN OF CORRECTION   PREFIX   TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX   PROVIDER'S PLAN OF CORRECTION   PROVIDER'S PLAN OF CORR		00799		B. WING		03/2	9/2018
MENNING REHABILITATION & HEALTHCARE C   907 MARSHALL AVENUE, PO BOX 57	NAME OF F	PROVIDER OR SUPPLIER		DRESS CITY S	STATE ZIP CODE	1 00/2	0/2010
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  21925  Continued From page 43  discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period and so at determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments.  This MN Requirement is not met as evidenced by:  Based on interview and document review, the facility failed to notify the ombudsman of facility initiated discharges for 3 of 3 residents (R6, R124, R22) who were discharged to the hospital.  Findings include:  R6's admission Minimum Data Set (MDS) dated 1/15/18, identified diagnoses which included hypertension and weakness.  R6's Progress Notes dated 2/1/18, at 9:42 a.m. indicated R6 began having emesis on 1/31/18, symptoms worsened, and R6 had been admitted			HEALTHCARE C 907 MARS	SHALL AVEN			
discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's endical or treatment program, the resident's endical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments.  This MN Requirement is not met as evidenced by:  Based on interview and document review, the facility failed to notify the ombudsman of facility initiated discharges for 3 of 3 residents (R6, R124, R22) who were discharged to the hospital.  Findings include:  R6's admission Minimum Data Set (MDS) dated 1/15/18, identified diagnoses which included hypertension and weakness.  R6's Progress Notes dated 2/1/18, at 9:42 a.m. indicated R6 began having emesis on 1/31/18, symptoms worsened, and R6 had been admitted	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETE
R124's quarterly MDS dated 3/1/18, identified	21925	discharge from the transfer to another notice shall include the proposed action telephone number ombudsman pursua Act, section 307(a) of this right, may chnotice period ends. shortened in situatic control, such as a creview, the accommersidents, a change treatment program, resident's welfare, oprohibited by the pupaying for the resid the medical record. reasonable effort to without disrupting residents and interview facility failed to notion initiated discharges R124, R22) who were residents admission Mir 1/15/18, identified to hypertension and were R6's Progress Note indicated R6 began symptoms worsened to the hospital at the	e facility and seven days before room within the facility. This the resident's right to contest n, with the address and of the area nursing home ant to the Older Americans (12). The resident, informed nose to relocate before the The notice period may be ons outside the facility's determination by utilization modation of newly-admitted in the resident's medical or the resident's own or another or nonpayment for stay unless ablic program or programs ent's care, as documented in Facilities shall make a caccommodate new residents oom assignments.  The notice period may be ons outside the facility's determination by utilization modation of newly-admitted in the resident's own or another or nonpayment for stay unless ablic program or programs ent's care, as documented in accommodate new residents own assignments.  The notice period may be ons outside the facility is for 3 of 3 residents (R6, ere discharged to the hospital.  The notice period may be ons outside the facility is determination by utilization modation of newly-admitted at time.	21925		on.	

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AND DUAN OF CODDECTION IN THE PROPERTY OF A		` ′	E CONSTRUCTION	(X3) DATE COMP		
00799		B. WING		03/2	9/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HENNIN	G REHABILITATION 8	EHFALIHGARF C	SHALL AVEN , MN 56551	IUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21925	Continued From pa	nge 44	21925			
		cluded diabetes mellitus, hronic obstructive pulmonary				
	presented with wea saturation of 83%, hospital emergency 10:25 p.m. facility r them R124 had bee	Notes dated 3/14/18, R124 akness and decreased oxygen had been sent R124 to y room (ER) for evaluation. At eceived a phone call informing en transferred to St. Cloud ion for pneumonia and ilure (CHF).				
	R22's Admission Record identified diagnoses which included anoxic brain damage, seizures and chronic obstructive pulmonary disease.					
	R22's Progress Notes on 3/4/18, indicated R22 had been sent to emergency department and admitted for aspiration pneumonia.					
	Review of R6, R124 and R22's medical records lacked documentation the notification of the facility initiated emergency transfer/discharge had been sent to the Long-Term Care (LTC) Ombudsman.					
	On 3/28/18, at 1:10 p.m. licensed social worker (LSW)-A confirmed she had not notified the ombudsman of R6, or R124's hospital transfers. LSW-A confirmed her usual practice did not include notifying the ombudsman of discharges, unless it was a "reportable" kind of discharge.					
	On 3/28/18, at 1:41 p.m. during a group interview with the regional director of clinical services (RDCS), administrator and director of nursing (DON), they indicated they was unaware of the need to notify the ombudsman of transfers and discharges. The administrator indicated they					

Minnesota Department of Health

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.			E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		00799	B. WING		03/2	19/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	•	
HENNIN	G REHABILITATION 8	HEALIHLAREL	SHALL AVEN 6, MN 56551	NUE, PO BOX 57		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21925	would update their the ombudsman.  SUGGESTED MET The Director of Socreview facility polici and discharge notif to ensure the ombuthe facility initiates	policy to include notification of THOD OF CORRECTION: cial Work or designee could es and procedures for transfer fication, and develop a system udsman is given notice when	21925	DEFICIENCY)		

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