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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: SSSP
Facility ID: 00629

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245325**

2. STATE VENDOR OR MEDICAID NO. (L2) **781843200**

3. NAME AND ADDRESS OF FACILITY
(L3) **FOLEY NURSING CENTER**
(L4) **253 PINE STREET**
(L5) **FOLEY, MN** (L6) **56329**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **09/06/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

12. Total Facility Beds **89** (L18)

13. Total Certified Beds **89** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	89			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Brenda Fischer, Unit Supervisor 09/06/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 10/20/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS
Posted 10/31/2016 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **08/30/2016** (L33)

DETERMINATION APPROVAL

CMS Certification Number (CCN): 245325
October 20, 2016

Mr. Andrew Huhta, Administrator
Foley Nursing Center
253 Pine Street
Foley, MN 56329

Dear Mr. Huhta:

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 the above facility is certified for or recommended for:

89 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 89 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 20, 2016

Mr. Andrew Huhta, Administrator
Foley Nursing Center
253 Pine Street
Foley, MN 56329

RE: Project Number S5325025

Dear Mr. Huhta:

On August 1, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 14, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On September 6, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 19, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 14, 2016, effective August 19, 2016 and therefore remedies outlined in our letter to you dated August 1, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245325	A. Building B. Wing	9/6/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLEY NURSING CENTER	253 PINE STREET FOLEY, MN 56329

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 08/19/2016	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	Correction Completed 08/19/2016	ID Prefix F0322 Reg. # 483.25(g)(2) LSC	Correction Completed 08/19/2016
ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 08/19/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) PK/KJ	DATE 10/20/2016	SIGNATURE OF SURVEYOR 10562	DATE 09/06/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/14/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

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(L4) **253 PINE STREET**
(L5) **FOLEY, MN** (L6) **56329**

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

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6. DATE OF SURVEY **07/14/2016** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 05 HHA, 09 ESRD, 13 PTIP, 22 CLIA, 02 SNF/NF/Dual, 06 PRTF, 10 NF, 14 CORF, 03 SNF/NF/Distinct, 07 X-Ray, 11 ICF/IID, 15 ASC, 04 SNF, 08 OPT/SP, 12 RHC, 16 HOSPICE

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

12.Total Facility Beds **89** (L18)

13.Total Certified Beds **89** (L17)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	89			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Michelle Koch, HFE NE II 08/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 08/29/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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_____ 2. Facility is not Eligible
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01-Merger, Closure
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04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS
Posted 08/30/2016 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 1, 2016

Mr. Andrew Huhta, Administrator
Foley Nursing Center
253 Pine Street
Foley, MN 56329

RE: Project Number S5325025

Dear Mr. Huhta:

On July 14, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Pam Kerssen, RN, APM
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Phone: (218) 308-2129
Fax: (218) 308-2122

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 August 23, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 October 14, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 14, 2017 (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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

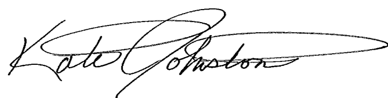
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



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

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245325	A. BUILDING ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLEY NURSING CENTER	253 PINE STREET FOLEY, MN 56329

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for 2 of 3 residents (R9, R63) who were dependant on staff for shaving. Findings include: R9's care plan dated 12/3/14, indicated R9 required extensive assistance with personal hygiene. R9's quarterly Minimum Data Set (MDS) dated 5/19/16, indicated R9 had moderate cognitive	F 282	Tag 0282 - 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (LONG TERM CARE FACILITIES) The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. The Foley Nursing Center reviewed care plan and group sheets pertaining to residents involved and added additional direction for facial shaving.	8/19/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 08/03/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245325	A. BUILDING ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLEY NURSING CENTER	**253 PINE STREET** **FOLEY, MN 56329**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 impairment and required extensive assistance with personal hygiene. R9 was observed on 7/11/16, at 1:43 p.m. to have numerous long facial hairs on her chin. R9 stated that staff were supposed to assist her with shaving her chin and wanted the hairs to be shaved. During observation of morning cares on 7/13/16, at 7:15 a.m., two days later, R9 continued to have numerous long chin hairs. Nursing assistant (NA)-A stated to R9 that she would go get the razor and shave her chin if she liked. R9 replied that would be good. NA-A did not obtain a razor and shave R9 during morning cares. R9 was observed again on 7/13/16, at 11:34 a.m. and at 1:26 p.m. and R9 still had not been shaved and still had numerous long hairs on her chin. R9 stated that she hoped she would come back and shave her. When interviewed on 7/13/16, at 1:27 p.m. NA-A stated that she had not shaved R9 yet today and that she should have been shaved on her bath day, which was last evening. NA-A further stated that R9's shaving could not have been completed with her bath, as the hairs on her chin were too long. R9's was scheduled to be bathed on Tuesday evenings. R9 had received her bath on 7/12/16 in the evening. When interviewed on 7/13/16, at 1:30 p.m. registered nurse (RN)-A stated that if facial hair is visible staff should offer to shave it for the resident and then shave them per their request.	F 282	CNA staff will be re-educated on policy and procedure related to plan of care and shaving policy and procedure at an all staff meeting on Tuesday August8th. Random weekly audits will be conducted by the care manager or designee to spot check residents on facial shaving as well as knowledge or resident care needs x 4 weeks with any inaccurate information to include on the spot re-education. Any noted patterns or trends will be reported to the quality assurance committee for further recommendations.	

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F 282	Continued From page 2 RN-A further stated that residents should not have to ask to be shaved. R63's care plan, revised 2/10/16, identified her as needing assistance with personal hygiene R63's significant change MDS dated 3/30/16, indicated R63 had moderate cognitive impairment, required extensive assistance with personal hygiene, and received hospice services. R63 was observed on 7/12/16, at 8:18 a.m. to have numerous long facial hairs on her chin. R63 was unable to state whether or not she wanted the hairs to be shaved. During observation 7/13/16, at 6:53 a.m. R63's morning cares were previously completed. She continued to have numerous long chin hairs. During interview that same day, at 12:52 p.m. NA-C acknowledged R63 had long chin hairs and needed to be shaved more often. NA-C further stated R63 never rejected cares and was shaved "once in a while." Later that same day, at 1:49 p.m. RN-C stated her expectation was for the residents to be shaved with morning cares and for the nursing assistants to be monitoring residents' appearances for being disheveled or unkept. After the interview, R63 continued to have long chin hairs and had not been shaved. During observations on 7/14/16, at 9:18 a.m. R63 was observed to be clean shaven. NA-D had assisted R63 with morning cares. NA-D stated he had assisted R63 with shaving that morning. He further stated the razor was kept in the tub room because residents were shaved on their bath	F 282		

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F 282	Continued From page 3 days. NA-D went on to state residents would be shaved in between bath days if hairs are noticed and hospice also shaved R63. Later that morning, at 9:50 a.m. hospice nurse (HN)-A stated hospice shaved R63 once a week on Tuesdays with her bath. The HN-A further stated R63 had not been shaved that week by hospice and would not have informed the facility staff about the lack of shaving since it was the responsibility of the facility to shave the residents, not hospice. Hospice Visit Note Reports and Residential Communication Notes, dated 7/11/16, indicated hospice had provided a social visit to R63 and had not shaved her. Further notes indicated 7/7/16, was the last time R63 had been shaved by hospice. Review of the current bath schedule, dated 5/6/16, indicated R63 received baths on 7/9/12 and 7/12/16, however, there was no indication R63 had been shaved on either of these days. A facility policy entitled: Shaving the Resident, last reviewed 3/14, directed staff to document resident shaving in the resident's medical record along with reporting the procedure to the charge nurse with any concerns.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		8/19/16

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F 312	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with shaving for 2 of 3 residents (R9, R63) reviewed for activities of daily living and who were dependent on staff for care. Findings include: R9's quarterly Minimum Data Set (MDS) dated 5/19/16, indicated R9 had moderate cognitive impairment and required extensive assistance with personal hygiene. R9's care plan dated 12/3/14, indicated R9 required extensive assistance with personal hygiene. R9 was observed on 7/11/16, at 1:43 p.m. to have numerous long facial hairs on her chin. R9 stated that staff were supposed to assist her with shaving her chin and wanted the hairs to be shaved. During observation of morning cares on 7/13/16, at 7:15 a.m., two days later, R9 continued to have numerous long chin hairs. Nursing assistant (NA)-A stated to R9 that she would go get the razor and shave her chin if she liked. R9 replied that would be good. NA-A did not obtain a razor and shave R9 during morning cares. R9 was observed again on 7/13/16, at 11:34 a.m. and at 1:26 p.m. and R9 still had not been shaved and still had numerous long hairs on her chin. R9 stated that she hoped she would come back and	F 312	Tag 0312 - 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (LONG TERM CARE FACILITIES) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. The Foley Nursing Center reviewed care plan and group sheets pertaining to residents involved and added additional direction for facial shaving. CNA staff will be re-educated on policy and procedure related to plan of care and shaving policy and procedure at an all staff meeting on Tuesday August8th. Random weekly audits will be conducted by the care manager or designee to spot check residents on facial shaving as well as knowledge or resident care needs x 4 weeks with any inaccurate information to include on the spot re-education. Any noted patterns or trends will be reported to	

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F 312	Continued From page 5 shave her. When interviewed on 7/13/16, at 1:27 p.m. NA-A stated that she had not shaved R9 yet today and that she should have been shaved on her bath day, which was last evening. NA-A further stated that R9's shaving could not have been completed with her bath, as the hairs on her chin were too long. R9's was scheduled to be bathed on Tuesday evenings. R9 had received her bath on 7/12/16 in the evening. When interviewed on 7/13/16, at 1:30 p.m. registered nurse (RN)-A stated that if facial hair is visible staff should offer to shave it for the resident and then shave them per their request. RN-A further stated that residents should not have to ask to be shaved. R63's significant change MDS dated 3/30/16, indicated R63 had moderate cognitive impairment, required extensive assistance with personal hygiene, and received hospice services. R63's care plan, revised 2/10/16, identified her as needing assistance with personal hygiene. R63 was observed on 7/12/16, at 8:18 a.m. to have numerous long facial hairs on her chin. R63 was unable to state whether or not she wanted the hairs to be shaved. During observation 7/13/16, at 6:53 a.m. R63's morning cares were previously completed. She continued to have numerous long chin hairs.	F 312	the quality assurance committee for further recommendations.	

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F 312	Continued From page 6 During interview that same day, at 12:52 p.m. NA-C acknowledged R63 had long chin hairs and needed to be shaved more often. NA-C further stated R63 never rejected cares and was shaved "once in a while." Later that same day, at 1:49 p.m. RN-C stated her expectation was for the residents to be shaved with morning cares and for the nursing assistants to be monitoring residents' appearances for being disheveled or unkept. After the interview, R63 continued to have long chin hairs and had not been shaved. During observations on 7/14/16, at 9:18 a.m. R63 was observed to be clean shaven. NA-D had assisted R63 with morning cares. NA-D stated he had assisted R63 with shaving that morning. He further stated the razor was kept in the tub room because residents were shaved on their bath days. NA-D went on to state residents would be shaved in between bath days if hairs are noticed and hospice also shaved R63. Later that morning, at 9:50 a.m. hospice nurse (HN)-A stated hospice shaved R63 once a week on Tuesdays with her bath. The HN-A further stated R63 had not been shaved that week by hospice and would not have informed the facility staff about the lack of shaving since it was the responsibility of the facility to shave the residents, not hospice. Hospice Visit Note Reports and Residential Communication Notes, dated 7/11/16, indicated hospice had provided a social visit to R63 and had not shaved her. Further notes indicated 7/7/16, was the last time R63 had been shaved by hospice.	F 312		

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F 312	Continued From page 7 Review of the current bath schedule, dated 5/6/16, indicated R63 received baths on 7/9/12 and 7/12/16, however, there was no indication R63 had been shaved on either of these days. A facility policy entitled: Shaving the Resident, last reviewed 3/14, directed staff to document resident shaving in the resident's medical record along with reporting the procedure to the charge nurse with any concerns.	F 312		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by:	F 322		8/19/16

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F 322	Continued From page 8	F 322		

Based on observation, interview, and document review, the facility failed to ensure nursing staff checked placement of a gastrostomy tube (G-tube) prior to infusing medication for 1 of 2 residents (R59).

Findings include:

R59's annual Minimum Data Set (MDS) dated 2/4/16, identified R59 received medications through his G-tube and consumed foods/fluids by mouth.

During observation of medication administration on 7/13/16, at 7:22 a.m. licensed practical nurse (LPN)-A set up R59's medications and brought a cup of crushed oral medications into his room. LPN-A removed R59's G-tube from under his t-shirt and connected an extender to his G-tube and poured 150 cc (cubic centimeters) of water into R59's G-tube. LPN-A proceeded to administer R59's medications and again flushed with 150 cc of water. LPN-A did not check the placement of R59's gastrostomy tube with a stethoscope before infusing his medications.

When interviewed on 7/13/16, at 8:12 a.m. regarding the feeding tube, LPN-A stated she was "nervous" and had forgotten to check for proper placement of the G-tube prior to administration of R59's medication. LPN-A stated it was the facility's policy to check placement prior to administration of medications into the G-tube and she had forgotten to do so. Further, LPN-A stated she should have checked the placement of R59's feeding tube prior to infusing medication to verify correct placement.

During interview on 7/13/16, at 7:42 a.m.

Tag 0322 - 483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (LONG TERM CARE FACILITIES)

Based on the comprehensive assessment of a resident, the facility must ensure that --

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

R59 mic-key button was placed by Centra Care GI and they were contacted regarding checking placement, fax received on 7/18/2016 stating" do not need to check placement with air prior to use."

Review with nurses during all staff meeting on 7/18/2016 and re-educated staff on policy and procedure related to tube feedings.

Care Manager or designee will perform a random audit on 2 residents per week x 4

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F 322	Continued From page 9 regarding R59 's feeding tube, registered nurse (RN)-A stated all licensed facility staff had received formal education on checking placement of G-tubes prior to instilling enteral nutrition or medications. RN-A further indicated it was important to check placement of R59's G-tube prior to instillation of medications to verify correct tube placement. A facility Enteral Nutritional Feeding policy, dated 4/24/15, identified a procedure which included, "Verify tube placement by forcefully injecting air into the tube while listening to the abdomen with stethoscope for a bubbling sound."	F 322	weeks to ensure proper process and procedure are used. Any noted patterns or trends will be reported to the quality assurance committee for further recommendations.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		8/19/16

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F 329	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure justification for the use of Seroquel (antipsychotic medication) for 1 of 5 residents (R28) reviewed for unnecessary medications. Findings include: R28's quarterly Minimum Data Set (MDS) dated 4/12/16, indicated R28 had severe cognitive impairment with a diagnosis of dementia without behavioral disturbances and major depressive disorder. R28's Psychotropic Drug Care Area Assessment (CAA) dated 1/14/16, specified R28 did not have a history of hallucinations or psychosis and Seroquel was used for management of behaviors related to her diagnosis of dementia. R28's care plan dated 7/12/16, identified R28 took an antidepressant medication Seroquel and Cymbalta related to depression. R28's care plan also indicated R28 had verbal and physical behavioral symptoms and was resistive towards personal cares. The care plan indicated the goal for R28 was to have fewer episodes of behavior review period. R28's behavioral charting from March through May 2016, indicated R28 had no change in behaviors and was often resistive/irritable towards staff during personal cares.	F 329	Tag 0329 - 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS (LONG TERM CARE FACILITIES) Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. R28 reviewed with Care Manager and Pharmacy Consultant and specific request was made to Mark Ziebarth, CNP,	

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F 329	Continued From page 11 R28's signed physician order sheet, dated 6/3/16, identified R28 began taking Seroquel 75 mg (milligrams) by mouth daily for severe major depression with psychotic behavior and Cymbalta 60 mg (an antidepressant medication) by mouth daily for depression on 1/1/2015. In October 2015, R28's scheduled Ativan (an antianxiety medication) was discontinued per family request and her Cymbalta was increased from 60 to 90 mg daily. In January 2016, R28 was started on a trial dose of Xanax (an antianxiety medication) and in March, 2016 R28 was ordered Xanax 0.25 mg by mouth every six hours as needed for anxiety. Review of physician progress notes from 8/24/15 through 4/8/16, did not identify the justification for the continued used of Seroquel nor was there any documentation mentioning gradual dose reductions (GDR) for R28's Seroquel. During interview on 7/13/16, at 1:05 p.m. registered nurse (RN)-A stated R28 had been on Seroquel over the last fifteen months and she was not aware of any GDR trials for this particular medication. RN-A further indicated the physician/psychologist progress notes did not justify the continued use of Seroquel and R28's behaviors had remained unchanged over the last several months. After interview with RN-A on 7/13/16, further documentation was provided from R28's advanced practice nurse (APRN) dated 7/14/16, explaining R28 was on Seroquel for short lived outbursts which were not continuous and were redirectable by staff. The facility policy titled, Psychotropic Medication	F 329	regarding needed dose reduction or documentation supporting reasons not to be reduced. Review policy and procedure with Care Managers for all units on 8/3/2016 regarding policy and procedure for medication reduction trials and guidance and education on this process. Form developed to streamline process by mailing out additional info statement to provider for approval on dose reduction or declination based on certain criteria. DON or designee to do random audits of one resident per month on psychotropic medication for appropriate documentation from both nursing staff and physician x 3 months. Then findings to be reviewed with Quality Assurance Committee for further recommendations.	

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F 329	Continued From page 12 Policy and Procedure dated 10/24/12, identified GDR's for psychotropic medications must be attempted in two separate quarters within the first year. After the first year, GDR's must be attempted annually thereafter. Documentation must be present from the prescriber explaining why a reduction or medication discontinuation is clinically contraindicated.	F 329		

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FOLEY NURSING CENTER	**253 PINE STREET** **FOLEY, MN 56329**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on July 14, 2016 . At the time of this survey, Foley Nursing Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This facility was surveyed as two separate buildings. Foley Nursing Center is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1970 and was determined to be of Type II(222) construction. In 1976, an addition was added to the north that was determined to be of Type V(111). In 1994 additions were added to the west of Units 2 & 4, additions to the Kitchen and Dining Room that were determined to be of Type II(000) construction and a Chapel addition to west of Unit 2 which was determined to be Type V(111) construction. In 2008 two additions were added to the facility , the North wing determined to be of type II(111) construction and the PT/OT addition determined to be of type II(111). Because the original building and the additions were constructed meet the construction type allowed for existing and new buildings, the facility was surveyed as two building. The building is fully sprinklered throughout. The	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE　　TITLE　　(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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245325	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**07/14/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLEY NURSING CENTER	**253 PINE STREET FOLEY, MN 56329**

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K 000	Continued From page 1 facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 89 beds and had a census of 66 at the time of the survey.	K 000		

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

F5325025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245325	A. BUILDING **02 - 2008 ADDITIONS** B. WING ______	**07/14/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLEY NURSING CENTER	**253 PINE STREET** **FOLEY, MN 56329**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on July 14, 2016. At the time of this survey, Foley Nursing Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Foley Nursing Center is a one story building with full basement. The building construction type has been determined to be Type II(111). In 2008 two additions were added to the facility , the North wing determined to be of type II(111) construction and the PT/OT addition determined to be of type II(111). This inspection only reflects the building that opened 9-04-08. It is properly separated from the original building constructed in 1971. The building is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 89 beds and had a census of 66 at the time of the survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
August 1, 2016

Mr. Andrew Huhta, Administrator
Foley Nursing Center
253 Pine Street
Foley, MN 56329

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5325025

Dear Mr. Huhta:

The above facility was surveyed on July 11, 2016 through July 14, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

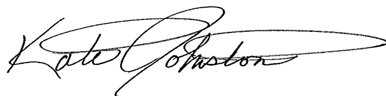
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Pam Kerssen, Assistant Program Manager at (218) 308-2129.

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,



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

Enclosure(s)
cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00629	A. BUILDING: ______ B. WING ______	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLEY NURSING CENTER	**253 PINE STREET FOLEY, MN 56329**

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On July 11-14, 2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		8/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00629	A. BUILDING: ______ B. WING ______	07/14/2016

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2 830	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with shaving for 2 of 3 residents (R9, R63) reviewed for activities of daily living and who were dependent on staff for care. Findings include: R9's quarterly Minimum Data Set (MDS) dated 5/19/16, indicated R9 had moderate cognitive impairment and required extensive assistance with personal hygiene. R9's care plan dated 12/3/14, indicated R9 required extensive assistance with personal hygiene. R9 was observed on 7/11/16, at 1:43 p.m. to have numerous long facial hairs on her chin. R9 stated that staff were supposed to assist her with shaving her chin and wanted the hairs to be shaved. During observation of morning cares on 7/13/16, at 7:15 a.m., two days later, R9 continued to have numerous long chin hairs. Nursing assistant (NA)-A stated to R9 that she would go get the razor and shave her chin if she liked. R9 replied that would be good. NA-A did not obtain a razor and shave R9 during morning cares. R9 was observed again on 7/13/16, at 11:34 a.m. and at 1:26 p.m. and R9 still had not been shaved and still had numerous long hairs on her chin. R9 stated that she hoped she would come back and shave her.	2 830	corrected	

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2 830	Continued From page 3	2 830		

When interviewed on 7/13/16, at 1:27 p.m. NA-A stated that she had not shaved R9 yet today and that she should have been shaved on her bath day, which was last evening. NA-A further stated that R9's shaving could not have been completed with her bath, as the hairs on her chin were too long.

R9's was scheduled to be bathed on Tuesday evenings. R9 had received her bath on 7/12/16 in the evening.

When interviewed on 7/13/16, at 1:30 p.m. registered nurse (RN)-A stated that if facial hair is visible staff should offer to shave it for the resident and then shave them per their request. RN-A further stated that residents should not have to ask to be shaved.

R63's significant change MDS dated 3/30/16, indicated R63 had moderate cognitive impairment, required extensive assistance with personal hygiene, and received hospice services.

R63's care plan, revised 2/10/16, identified her as needing assistance with personal hygiene.

R63 was observed on 7/12/16, at 8:18 a.m. to have numerous long facial hairs on her chin. R63 was unable to state whether or not she wanted the hairs to be shaved.

During observation 7/13/16, at 6:53 a.m. R63's morning cares were previously completed. She continued to have numerous long chin hairs.

During interview that same day, at 12:52 p.m. NA-C acknowledged R63 had long chin hairs and needed to be shaved more often. NA-C further stated R63 never rejected cares and was shaved

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2 830	Continued From page 4	2 830		

"once in a while."

Later that same day, at 1:49 p.m. RN-C stated her expectation was for the residents to be shaved with morning cares and for the nursing assistants to be monitoring residents' appearances for being disheveled or unkept. After the interview, R63 continued to have long chin hairs and had not been shaved.

During observations on 7/14/16, at 9:18 a.m. R63 was observed to be clean shaven. NA-D had assisted R63 with morning cares. NA-D stated he had assisted R63 with shaving that morning. He further stated the razor was kept in the tub room because residents were shaved on their bath days. NA-D went on to state residents would be shaved in between bath days if hairs are noticed and hospice also shaved R63.

Later that morning, at 9:50 a.m. hospice nurse (HN)-A stated hospice shaved R63 once a week on Tuesdays with her bath. The HN-A further stated R63 had not been shaved that week by hospice and would not have informed the facility staff about the lack of shaving since it was the responsibility of the facility to shave the residents, not hospice.

Hospice Visit Note Reports and Residential Communication Notes, dated 7/11/16, indicated hospice had provided a social visit to R63 and had not shaved her. Further notes indicated 7/7/16, was the last time R63 had been shaved by hospice.

Review of the current bath schedule, dated 5/6/16, indicated R63 received baths on 7/9/12 and 7/12/16, however, there was no indication R63 had been shaved on either of these days.

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2 830	Continued From page 5 A facility policy entitled: Shaving the Resident, last reviewed 3/14, directed staff to document resident shaving in the resident's medical record along with reporting the procedure to the charge nurse with any concerns. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could review and reeducate all staff on the policies and procedures to ensure that all residents are groomed to assure comfort and maintain personal appearance and hygiene. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function.	2 930		8/15/16

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2 930	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nursing staff checked placement of a gastrostomy tube (G-tube) prior to infusing medication for 1 of 2 residents (R59). Findings include: R59's annual Minimum Data Set (MDS) dated 2/4/16, identified R59 received medications through his G-tube and consumed foods/fluids by mouth. During observation of medication administration on 7/13/16, at 7:22 a.m. licensed practical nurse (LPN)-A set up R59's medications and brought a cup of crushed oral medications into his room. LPN-A removed R59's G-tube from under his t-shirt and connected an extender to his G-tube and poured 150 cc (cubic centimeters) of water into R59's G-tube. LPN-A proceeded to administer R59's medications and again flushed with 150 cc of water. LPN-A did not check the placement of R59's gastrostomy tube with a stethoscope before infusing his medications. When interviewed on 7/13/16, at 8:12 a.m. regarding the feeding tube, LPN-A stated she was "nervous" and had forgotten to check for proper placement of the G-tube prior to administration of R59's medication. LPN-A stated it was the facility's policy to check placement prior to administration of medications into the G-tube and she had forgotten to do so. Further, LPN-A stated she should have checked the placement of R59's feeding tube prior to infusing medication to verify correct placement.	2 930	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 930	Continued From page 7 During interview on 7/13/16, at 7:42 a.m. regarding R59 's feeding tube, registered nurse (RN)-A stated all licensed facility staff had received formal education on checking placement of G-tubes prior to instilling enteral nutrition or medications. RN-A further indicated it was important to check placement of R59's G-tube prior to instillation of medications to verify correct tube placement. A facility Enteral Nutritional Feeding policy, dated 4/24/15, identified a procedure which included, "Verify tube placement by forcefully injecting air into the tube while listening to the abdomen with stethoscope for a bubbling sound." SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure residents with tube feedings have the placement of the tube feeding properly checked and medications are administered separately. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease	21426		8/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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FOLEY NURSING CENTER	**253 PINE STREET FOLEY, MN 56329**

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21426	Continued From page 8 Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a step 1 tuberculin skin test (TST) was completed within three months of hire or at the time of hire for 2 of 5 employees (NA-B, RN-B) reviewed for TB screening. Findings include: Nursing assistant (NA)-B was hired on 6/7/16. NA-B had a TB screening completed at the time of hire by the facility on 6/7/16, however a step 1 TST was not done. The facility accepted an outside step 1 TST completed on 12/7/15 and a step 2 TST completed on 12/29/15. Registered nurse (RN)-B was hired on 6/13/16. RN-B had a TB screening completed at the time of hire by the facility on 6/13/16, however, a step 1 TST was not done. The facility had accepted an outside step 1 TST completed on 12/16/15 and a	21426	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00629	A. BUILDING: ______ B. WING ______	07/14/2016

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21426	Continued From page 9 step 2 TST completed on 12/28/15. When interviewed on 7/14/16, at 10:25 a.m. the director of nursing (DON) verified the forms received at the time of hire were more than three months old. The DON further stated that the facility practice was to accept TB screenings and TST results that were completed within the last year of being hired. The facility policy Tuberculosis Screening and Program for Residents and Employee's dated 5/16, indicated that a screening for tuberculosis and first step of a two-step Mantoux would be completed upon hire. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could inservice staff regarding current tuberculosis regulations for health care facilities and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the	21540		8/15/16

Minnesota Department of Health

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21540	Continued From page 10	21540		

matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure justification for the use of Seroquel (antipsychotic medication) for 1 of 5 residents (R28) reviewed for unnecessary medications.

corrected

Findings include:

R28's quarterly Minimum Data Set (MDS) dated 4/12/16, indicated R28 had severe cognitive impairment with a diagnosis of dementia without behavioral disturbances and major depressive disorder. R28's Psychotropic Drug Care Area Assessment (CAA) dated 1/14/16, specified R28 did not have a history of hallucinations or psychosis and Seroquel was used for management of behaviors related to her diagnosis of dementia.

R28's care plan dated 7/12/16, identified R28 took an antidepressant medication Seroquel and Cymbalta related to depression. R28's care plan also indicated R28 had verbal and physical behavioral symptoms and was resistive towards personal cares. The care plan indicated the goal

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for R28 was to have fewer episodes of behavior review period. R28's behavioral charting from March through May 2016, indicated R28 had no change in behaviors and was often resistive/irritable towards staff during personal cares.

R28's signed physician order sheet, dated 6/3/16, identified R28 began taking Seroquel 75 mg (milligrams) by mouth daily for severe major depression with psychotic behavior and Cymbalta 60 mg (an antidepressant medication) by mouth daily for depression on 1/1/2015. In October 2015, R28's scheduled Ativan (an antianxiety medication) was discontinued per family request and her Cymbalta was increased from 60 to 90 mg daily. In January 2016, R28 was started on a trial dose of Xanax (an antianxiety medication) and in March, 2016 R28 was ordered Xanax 0.25 mg by mouth every six hours as needed for anxiety.

Review of physician progress notes from 8/24/15 through 4/8/16, did not identify the justification for the continued used of Seroquel nor was there any documentation mentioning gradual dose reductions (GDR) for R28's Seroquel.

During interview on 7/13/16, at 1:05 p.m. registered nurse (RN)-A stated R28 had been on Seroquel over the last fifteen months and she was not aware of any GDR trials for this particular medication. RN-A further indicated the physician/psychologist progress notes did not justify the continued use of Seroquel and R28's behaviors had remained unchanged over the last several months.

After interview with RN-A on 7/13/16, further documentation was provided from R28's

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advanced practice nurse (APRN) dated 7/14/16, explaining R28 was on Seroquel for short lived outbursts which were not continuous and were redirectable by staff.

The facility policy titled, Psychotropic Medication Policy and Procedure dated 10/24/12, identified GDR's for psychotropic medications must be attempted in two separate quarters within the first year. After the first year, GDR's must be attempted annually thereafter. Documentation must be present from the prescriber explaining why a reduction or medication discontinuation is clinically contraindicated.

A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents do not receive unnecessary medications, ensure all medications include parameters, and educate all relevant staff. The DON or designee can develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee.

TIME PERIOD FOR CORRECTION: Fourteen (14) days.