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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: TGQ8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00669

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245585**

2.STATE VENDOR OR MEDICAID NO.
(L2) **145240100**

3. NAME AND ADDRESS OF FACILITY
(L3) **TRAVERSE CARE CENTER**
(L4) **303 SEVENTH STREET SOUTH**
(L5) **WHEATON, MN** (L6) **56296**

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) **12/01/2010**

6. DATE OF SURVEY **03/16/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Gail Anderson, HFE NEII — 03/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 05/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/24/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5585

On March 12, 2014, a Post Certification Revisit was completed and by review of the facility's plan of correction. Based on the plan of correction we have determined the facility has corrected the deficiencies pursuant to the January 24, 2014 standard survey, effective March 5, 2014. Refer to the CMS 2567b for the results of this visit.

Effective March 5, 2014, the facility is certified for 49 nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5585

May 16, 2014

Ms. Chelsey Stattleman, Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, MN 56296

Dear Ms. Stattleman:

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 March 5, 2014 the above facility is certified for:

49 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,
Mark Meath, Enforcement Specialist
Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 16, 2014

Ms. Chelsey Stattleman, Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, Minnesota 56296

RE: Project Number S5585024

Dear Ms. Stattleman:

On February 10, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 24, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On March 12, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 24, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 5, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 24, 2014, effective March 5, 2014 and therefore remedies outlined in our letter to you dated February 10, 2014, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us
Enclosure

cc: Licensing and Certification File 5585r14.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245585	A. Building B. Wing	3/12/2014

Name of Facility	Street Address, City, State, Zip Code
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **03/05/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/05/2014**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **03/05/2014**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/05/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **03/05/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/05/2014**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/05/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/05/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/05/2014**
ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **03/05/2014**	ID Prefix **F0464** Reg. # **483.70(g)** LSC	Correction Completed **03/05/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/GA	3/16/2014	28034	03/12/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/24/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: TGQ8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00669

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245585**

2.STATE VENDOR OR MEDICAID NO.
(L2) **145240100**

3. NAME AND ADDRESS OF FACILITY
(L3) **TRAVERSE CARE CENTER**
(L4) **303 SEVENTH STREET SOUTH**
(L5) **WHEATON, MN** (L6) **56296**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/01/2010**

6. DATE OF SURVEY **01/24/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 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)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE NEII 02/27/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
MPM
Mark Meath, Program Specialist 03/22/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-558

At the time of the January 24, 2014 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8156

February 10, 2014

Ms. Chelsey Stattleman, Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, Minnesota 56296

RE: Project Number S5585024

Dear Ms. Stattleman:

On January 24, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and
<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537-3858

Telephone: (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 March 5, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 April 24, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 24, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
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
	245585	A. BUILDING _____ B. WING _____	01/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

(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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	

2-27-14 RC E addendum 80

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2-19-2014

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

RECEIVED
FEB 24 2014
MN Dept of Health
Fergus Falls

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	01/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

(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 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to thoroughly investigate and immediately report to the state agency (SA) and facility administrator, instances of potential abuse or mistreatment, for 1 of 1 resident (R47) who reported allegations of physical abuse, for 4 of 4 residents (R4, R34, R40 and R42) reviewed with bruises of unknown origin, and for 1 of 3 resident abuse reports (R22) reviewed for abuse prohibition. Findings include: R47 alleged she was physically and verbally abused by a facility employee and had reported her allegation to facility personnel; however, the allegation was not thoroughly investigated and was not reported to the SA. The quarterly Minimum Data Set (MDS) dated 11/28/13, indicated R47 was cognitively intact and required assistance of one staff for dressing and bathing. R47 was independent with all other	F 225	**F225** • The facility will immediately report and thoroughly investigate any allegations or suspicions of abuse, neglect or suspicious injuries as per facility policy. • Staff will be educated on facility abuse and neglect policy upon hire, annually and prn. • Re-education shall include: the process of filing and reporting of suspicions of abuse, neglect or suspicious injury. Education shall also include reporting to the Administrator and to the state agency for injuries of unknown origin. • IDT will review any reports at daily stand up meeting and there will be a weekly audit by Nurse Managers or designee for three months and then randomly after that. • QAA will review audits for three months to review for trends. • Completion date by: 3/5/2014	

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F 225	Continued From page 2 activities of daily living (ADLs). During interview on 1/22/14, at 9:52 a.m. R47 reported that during a bath a couple of months prior, an unidentified nursing assistant (NA) physically tried to push her in the tub and also yelled at her. When interviewed again on 1/23/14, at 9:30 a.m., R47 stated the NA physically tried to push her in the tub when she was seated on the tub chair. R47 reported the chair was not locking into place, the NA gave the chair a "good hard push," and then R47 screamed. Next, the NA "elbowed or shouldered" R47, back into the chair when R47 tried to get out of the chair. R47 told the NA if she pushed her one more time that she was going to get out of there [the tub room]. Then the NA pushed her again, at which time R47 attempted to stand up. The NA would not let R47 stand up. R47 reported she then pushed the NA and got her robe on, after that, the NA yelled at her. R47 stated she reported the incident to a staff member right away. R47 could not recall the date when the incident occurred or which staff member she reported it to. R47 stated that the NA had not worked with her since the incident, and she believed that the NA no longer worked at the facility because she had not seen her since the incident. On 1/23/14, all abuse reports completed by the facility were reviewed. There was no report or investigation found in relation to R47's allegation of abuse. During interview on 1/24/14, at 9:36 a.m. the administrator verified R47 did tell her about a staff member that was rough with her during bathing, "I think the next day," when she was helping R47	F 225		

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F 225	Continued From page 3 with cares in the morning. The administrator stated R47 reported the shower chair got stuck and the staff was rough with her. The administrator added, she told R47 that she felt the NAs actions were likely because they were worried about R47's safety. Then the administrator stated, "I justified it to her." The administrator verified she did not investigate the allegation further because R47 reported she thought the staff member had dark hair and there was no staff member with dark hair that the administrator could recall who worked with R47. The administrator also confirmed that she did not report the allegation to the SA. The administrator stated the facility's usual practice was to immediately report any allegations of abuse to the SA and then conduct a thorough investigation. The administrator denied doing any investigation and stated she "maybe should have." During interview on 1/24/14, at 10:25 a.m. the director of nursing (DON) confirmed R47 also spoke with her regarding the bath incident. The DON stated that R47 was able to describe the NA involved. The DON reported she then interviewed the NA and received information regarding the incident during R47's bath. The DON concluded that the issue was with the bath chair, and was not intentional or directed at R47. The DON then spoke with R47 and explained to her what the NAs reported to her. The DON stated that along with R47, the consensus was the whole incident was just a misunderstanding. The DON confirmed that she did not document the visit or the interviews that were conducted, and stated she would have documented something if R47 felt there was still an issue or had further concerns. The DON confirmed R47 was never assessed for injuries after the alleged	F 225		

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F 225	Continued From page 4 incident. The DON confirmed there was no formal investigation process completed or report made to the SA related to R47's allegation. R4, R34, R40 and R42 had bruising of unknown origin that was suspicious in nature and/or location, which were not investigated or reported to the SA. In addition, R42's bruising was not reported to the facility administrator. The quarterly MDS dated 12/5/13, indicated R4's diagnosis included cerebrovascular accident (CVA) and severe cognitive loss, with short and long term memory impairment. The MDS also indicated R4 needed extensive assistance for all ADLs. R4's Injury report dated 11/18/13, identified a three centimeter (cm) x four cm, light purple bruise to her inner-left thigh. The report indicated that R4 was unaware of how the bruise occurred. The report noted that it was hard to understand what R4 was saying at times and you needed to listen closely. No further investigation of the bruising or indication it was reported to the SA could be located in R4's medical record. The annual MDS dated 11/14/13, indicated R34's diagnoses included Alzheimer's disease and severe cognitive impairment. The MDS also indicated R34 required extensive to total assistance with all ADLs. R34's Injury report dated 1/16/14, identified a 4.5 cm x five cm bruise to his inner-right arm and a four cm x five cm bruise on his right forearm. The report indicated R34 was unable to give explanation of how the bruises occurred. No further investigation of the bruising or indication it was reported to the SA could be located in R34's medical record. The quarterly MDS dated 10/31/13, indicated	F 225		

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F 225	Continued From page 5 R40's diagnoses included dementia and severe cognitive impairment. The MDS also indicated R40 needed extensive assistance for all ADLs. R40's Injury report dated 11/18/13, identified a seven cm x two cm bruise under her left breast. The report indicated R40 was unable to give explanation of how the bruise occurred. No further investigation of the bruising or indication it was reported to the SA could be located in R40's medical record. The annual MDS dated 12/30/13, indicated R42's diagnoses included depressive disorder and severe cognitive impairment. The MDS also indicated R42 needed total assistance for all ADLs. R42's Injury report dated 11/25/13, identified a dark pink, quarter-sized bruise, with a small open area to the middle of his neck. The report indicated that R42 did not know how this injury occurred and stated "I'm fine." No further investigation of the bruising or indication it was reported to the facility administrator or the SA, could be located in R42's medical record. During interview on 1/24/14, at 10:30 a.m. the DON stated that she expected bruises of unknown origin, in an area not vulnerable to trauma, be reported right away to the SA and then investigated. The DON confirmed that each of the injury reports listed above should have been reported to the SA and further investigated, due to the locations of the bruising. During interview on 1/24/14, at 6:03 p.m. the administrator confirmed that she was not notified regarding the Injury Report dated 11/25/13, for R42. She stated, "I don't even remember this or hearing about it at all."	F 225		

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F 225	Continued From page 6 R22 had bruising of unknown origin that was suspicious in nature and/or location, but was not reported to the SA immediately. Review of an abuse incident report dated 12/16/13, revealed R22 had a bruise of unknown origin that was discovered on 12/14/13, by a NA who was helping R22 to the bathroom. The bruise was described as ten cm x six cm, located on her inner-right thigh. R22 reported she did not know how the bruise happened. The facility did not report this incident to the SA until 12/16/13. During an interview on 1/24/14, at 11:26 a.m. the DON reported that the NA noticed R22's bruise on 12/14/13, but did not report it to anyone else until 12/16/13. The DON stated after the NA reported the bruise, the facility made a report to the SA right away. The DON confirmed that the NA should have reported the bruise to the nurses immediately. During interview on 1/22/14, at 4:34 p.m. the administrator stated employees were expected to report large bruises or any bruises in suspicious areas, such as in the perineal area, to the charge nurse right away. She added that she was then to be notified right away and if she was not at the facility, the staff called her on the telephone. The administrator reported that the charge nurses were expected to complete the initial report to the SA if she or the DON were not in the building. The administrator stated that the investigations were completed after the initial report was made to the SA. The facility did not ensure appropriate background studies were obtained for NA-F and NA-G.	F 225		

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F 225	Continued From page 7 Per review of her personnel record, NA-F was hired as a NA on 10/4/13; however, NA-F's current pre-screening was completed by the state's personal care assistance program, rather than the state's required background study program. Per review of her personnel record, NA-G was hired as a NA on 4/24/13; however, NA-G's current pre-screening was completed by the state's personal care assistance program, rather than the state's required background study program. During interview on 1/24/14, at 10:00 a.m., the administrator confirmed both NA-F and NA-G currently worked in the facility. The administrator reported that she was told the employees could work, but could not recall who had informed her of this. Review of the NA registry revealed both NA-F and NA-G remained current on their registrations, with no restrictions or concerns noted. Review of the facility's Abuse Prevention/Resident Treatment Policy dated 11/11, confirmed that allegations of abuse and injuries of unknown sources were reported immediately to the administrator of the facility, and were also reported immediately to the SA. The facility was to investigate each alleged violation thoroughly and report the results of all investigations to the administrator, as well as the SA. The policy defined injury of unknown source as follows: "If the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of	F 225		

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F 225	Continued From page 8 the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time." The policy also indicated that all applicants for employment in the facility were to have criminal background checks in accordance with state law.	F 225	**F226** • The facility will immediately report and thoroughly investigate any allegations of suspicions of abuse, neglect or suspicious injuries. • Re-education will include the need for timely reporting to the state agency. Administrator will be notified immediately of injuries of unknown origin. • HR has received education on properly obtaining employee background checks. • The facility will ensure that all back round studies initiated and stage on all newly hired employees. • Administrator/ Designee will audit new employees' records to assure background checks are being completed. • IDT will review any reports at daily stand up meeting and there will be a weekly audit by Nurse Managers or designee for three months and then randomly after that. • QAA will review audits for three months to review for trends. • Completion date by: 3/5/2014	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse prohibition policies and procedures for thorough investigations and immediate reporting to the state agency (SA) and facility administrator, instances of potential abuse or mistreatment, for 1 of 1 resident (R47) who reported allegations of physical abuse, for 4 of 4 residents (R4, R34, R40 and R42) reviewed with bruises of unknown origin, and for 1 of 3 resident abuse reports (R22) reviewed for abuse prohibition. In addition, the facility failed to implement employee pre-screening policies by submitting screenings to the appropriate program for the state's criminal background study, for 2 of 6 employees (NA-F and NA-G) reviewed for pre-screening. This had the potential to affect all 47 of 47 residents who resided in the facility, with no potential for harm.	F 226		

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F 226	Continued From page 9 Findings include: The facility's Abuse Prevention/Resident Treatment Policy dated 11/11, directed allegations of abuse and injuries of unknown sources be reported immediately to the administrator of the facility, and also reported immediately to the SA. The facility was to investigate each alleged violation thoroughly and report the results of all investigations to the administrator, as well as the SA. The policy defined injury of unknown source as follows: "If the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time." The policy also indicated that all applicants for employment in the facility were to have criminal background checks in accordance with state law. R47 alleged she was physically and verbally abused by a facility employee and had reported her allegation to facility personnel; however, the allegation was not thoroughly investigated and was not reported to the SA. The quarterly Minimum Data Set (MDS) dated 11/28/13, indicated R47 was cognitively intact and required assistance of one staff for dressing and bathing. R47 was independent with all other activities of daily living (ADLs). During interview on 1/22/14, at 9:52 a.m. R47 reported that during a bath a couple of months	F 226		

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F 226	Continued From page 10	F 226		

prior, an unidentified nursing assistant (NA) physically tried to push her in the tub and also yelled at her. When interviewed again on 1/23/14, at 9:30 a.m., R47 stated the NA physically tried to push her in the tub when she was seated on the tub chair. R47 reported the chair was not locking into place, the NA gave the chair a "good hard push," and then R47 screamed. Next, the NA "elbowed or shouldered" R47, back into the chair when R47 tried to get out of the chair. R47 told the NA if she pushed her one more time that she was going to get out of there [the tub room]. Then the NA pushed her again, at which time R47 attempted to stand up. The NA would not let R47 stand up. R47 reported she then pushed the NA and got her robe on, after that, the NA yelled at her. R47 stated she reported the incident to a staff member right away. R47 could not recall the date when the incident occurred or which staff member she reported it to. R47 stated that the NA had not worked with her since the incident, and she believed that the NA no longer worked at the facility because she had not seen her since the incident.

On 1/23/14, all abuse reports completed by the facility were reviewed. There was no report or investigation found in relation to R47's allegation of abuse.

During interview on 1/24/14, at 9:36 a.m. the administrator verified R47 did tell her about a staff member that was rough with her during bathing, "I think the next day," when she was helping R47 with cares in the morning. The administrator stated R47 reported the shower chair got stuck and the staff was rough with her. The administrator added, she told R47 that she felt

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F 226	Continued From page 11 the NAs actions were likely because they were worried about R47's safety. Then the administrator stated, "I justified it to her." The administrator verified she did not investigate the allegation further because R47 reported she thought the staff member had dark hair and there was no staff member with dark hair that the administrator could recall who worked with R47. The administrator also confirmed that she did not report the allegation to the SA. The administrator stated the facility's usual practice was to immediately report any allegations of abuse to the SA and then conduct a thorough investigation. The administrator denied doing any investigation and stated she "maybe should have." During interview on 1/24/14, at 10:25 a.m. the director of nursing (DON) confirmed R47 also spoke with her regarding the bath incident. The DON stated that R47 was able to describe the NA involved. The DON reported she then interviewed the NA and received information regarding the incident during R47's bath. The DON concluded that the issue was with the bath chair, and was not intentional or directed at R47. The DON then spoke with R47 and explained to her what the NAs reported to her. The DON stated that along with R47, the consensus was the whole incident was just a misunderstanding. The DON confirmed that she did not document the visit or the interviews that were conducted, and stated she would have documented something if R47 felt there was still an issue or had further concerns. The DON confirmed R47 was never assessed for injuries after the alleged incident. The DON confirmed there was no formal investigation process completed or report made to the SA related to R47's allegation.	F 226		

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F 226	Continued From page 12 R4, R34, R40 and R42 had bruising of unknown origin that was suspicious in nature and/or location, which were not investigated or reported to the SA. In addition, R42's bruising was not reported to the facility administrator. The quarterly MDS dated 12/5/13, indicated R4's diagnosis included cerebrovascular accident (CVA) and severe cognitive loss, with short and long term memory impairment. The MDS also indicated R4 needed extensive assistance for all ADLs. R4's Injury report dated 11/18/13, identified a three centimeter (cm) x four cm, light purple bruise to her inner-left thigh. The report indicated that R4 was unaware of how the bruise occurred. The report noted that it was hard to understand what R4 was saying at times and you needed to listen closely. No further investigation of the bruising or indication it was reported to the SA could be located in R4's medical record. The annual MDS dated 11/14/13, indicated R34's diagnoses included Alzheimer's disease and severe cognitive impairment. The MDS also indicated R34 required extensive to total assistance with all ADLs. R34's Injury report dated 1/16/14, identified a 4.5 cm x five cm bruise to his inner-right arm and a four cm x five cm bruise on his right forearm. The report indicated R34 was unable to give explanation of how the bruises occurred. No further investigation of the bruising or indication it was reported to the SA could be located in R34's medical record. The quarterly MDS dated 10/31/13, indicated R40's diagnoses included dementia and severe cognitive impairment. The MDS also indicated R40 needed extensive assistance for all ADLs. R40's Injury report dated 11/18/13, identified a	F 226		

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seven cm x two cm bruise under her left breast. The report indicated R40 was unable to give explanation of how the bruise occurred. No further investigation of the bruising or indication it was reported to the SA could be located in R40's medical record.

The annual MDS dated 12/30/13, indicated R42's diagnoses included depressive disorder and severe cognitive impairment. The MDS also indicated R42 needed total assistance for all ADLs. R42's Injury report dated 11/25/13, identified a dark pink, quarter-sized bruise, with a small open area to the middle of his neck. The report indicated that R42 did not know how this injury occurred and stated "I'm fine." No further investigation of the bruising or indication it was reported to the facility administrator or the SA, could be located in R42's medical record.

During interview on 1/24/14, at 10:30 a.m. the DON stated that she expected bruises of unknown origin, in an area not vulnerable to trauma, be reported right away to the SA and then investigated. The DON confirmed that each of the injury reports listed above should have been reported to the SA and further investigated, due to the locations of the bruising.

During interview on 1/24/14, at 6:03 p.m. the administrator confirmed that she was not notified regarding the Injury Report dated 11/25/13, for R42. She stated, "I don't even remember this or hearing about it at all."

R22 had bruising of unknown origin that was suspicious in nature and/or location, but was not reported to the SA immediately.

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F 226	Continued From page 14 Review of an abuse incident report dated 12/16/13, revealed R22 had a bruise of unknown origin that was discovered on 12/14/13, by a NA who was helping R22 to the bathroom. The bruise was described as ten cm x six cm, located on her inner-right thigh. R22 reported she did not know how the bruise happened. The facility did not report this incident to the SA until 12/16/13. During an interview on 1/24/14, at 11:26 a.m. the DON reported that the NA noticed R22's bruise on 12/14/13, but did not report it to anyone else until 12/16/13. The DON stated after the NA reported the bruise, the facility made a report to the SA right away. The DON confirmed that the NA should have reported the bruise to the nurses immediately. During interview on 1/22/14, at 4:34 p.m. the administrator stated employees were expected to report large bruises or any bruises in suspicious areas, such as in the perineal area, to the charge nurse right away. She added that she was then to be notified right away and if she was not at the facility, the staff called her on the telephone. The administrator reported that the charge nurses were expected to complete the initial report to the SA if she or the DON were not in the building. The administrator stated that the investigations were completed after the initial report was made to the SA. The facility did not ensure appropriate background studies were obtained for NA-F and NA-G. Per review of her personnel record, NA-F was hired as a NA on 10/4/13; however, NA-F's current pre-screening was completed by the	F 226		

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F 226	Continued From page 15 state's personal care assistance program, rather than the state's required background study program. Per review of her personnel record, NA-G was hired as a NA on 4/24/13; however, NA-G's current pre-screening was completed by the state's personal care assistance program, rather than the state's required background study program. During interview on 1/24/14, at 10:00 a.m., the administrator confirmed both NA-F and NA-G currently worked in the facility. The administrator reported that she was told the employees could work, but could not recall who had informed her of this. Review of the NA registry revealed both NA-F and NA-G remained current on their registrations, with no restrictions or concerns noted.	F 226		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure each resident room was well maintained for a homelike environment, for 4 of 4 residents (R25, R34, R47 and R48) whose rooms were observed to be in need of repair. Findings include:	F 253		

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F 253	Continued From page 16 An environmental tour was performed with the plant operations manager (POM) on 1/24/14, at 9:37 a.m., during which the following was observed: The south wall of R47's room, behind her recliner chair, there were ten divot-like depressions in the wall. POM stated he was aware of the depressions and had pulled her recliner chair away from the wall to prevent further damage. POM confirmed the wall was still in need of repair. In R34's room, there was a large gouged area on the south wall, which ran approximately 12 inches in length, three feet above the floor. Paint and sheetrock paper were missing and a thin coat of bumpy plaster covered the gouged area. In the bathroom near the doorway, there were three additional, three by four centimeter (cm) gouges in the sheetrock, near the brown rubber baseboard. Also, the vertical edge of the rubber baseboard, to the right of the doorway (facing the resident room), was loose from the wall. POM stated he was not aware of the areas and confirmed the exposed sheetrock was a non-cleanable surface. He also confirmed the loose baseboard was a need for repair. In R48 and R25's shared room, the vertical edge of the rubber baseboard, at the entrance to the bathroom, was loose from the wall. There were also three, two by three cm areas of chipped tile next to the baseboard, which created a non-cleanable surface. POM confirmed the non-cleanable surface and loose baseboard. POM stated he was not aware of the areas and indicated they were a need of repair.	F 253	**F253** • Residents# 25, 34, 47 and 48 have had repairs in their rooms completed. • Maintenance Director will establish a routine schedule to assure all patient rooms are checked weekly on a rotating basis to assure any needed repairs are done. • Maintenance Director will complete weekly audits to assure needed repairs have been completed. • QAA will review audits for three months to review for. • Completion date by: 3/5/14	

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F 253	Continued From page 17 On 1/24/14, at 1:37 p.m., POM stated there was one maintenance assistant, in addition to himself. He reported information about maintenance issues in resident rooms was communicated to them verbally, or a maintenance slip was completed, with copies sent to the maintenance department. Although the facility had a system for reporting maintenance concerns, POM was unaware of the loose baseboards, areas of chipped tile and gouges in the sheetrock. POM stated the maintenance assistant was checking resident rooms for needed repairs; however, the POM verified there was no organized plan for resident room repairs, or documentation of audits performed to check for needed repairs in resident rooms. A facility policy for resident room maintenance was requested, but none was provided.	F 253		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct a	F 314	**F314** • Resident # 23 superficial stage 2 ulcer has healed. • LN /NAR's shall be educated on reporting any new skin concerns to the DON/Designee to assure facility policy for skin is followed. Education to include preventing the development of pressure ulcers, reviewing staff on observation, monitoring and implementing interventions. • Nurse Manager will audit weekly for three months then randomly. QA will review audits for three months to review for trends. • Completion date by: 3/5/14	

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F 314	Continued From page 18 comprehensive skin assessment to prevent further development of pressure ulcers for 1 of 1 resident (R23) identified with a current pressure ulcer. Findings include: R23's annual Minimum Data Set (MDS) dated 8/23/13, noted diagnoses including diabetes, dementia, arthritis, incontinence and impaired renal function. The MDS identified R23 had a severe cognitive impairment and required a pressure reduction surface while in her bed and wheelchair. The MDS revealed R23 required extensive assistance with bed mobility and total staff assistance with transfers. The MDS did not identify R23 was at risk for pressure ulcers and did not identify she required repositioning assistance. The quarterly MDS dated 11/7/13, identified R23 required extensive assistance with bed mobility, transfers and did not ambulate. Further, the MDS did not identify R23 was at risk for development of pressure ulcers. Review of the Quarterly Care Conference Multidisciplinary note dated 11/12/13, revealed R23 was incontinent of bowel and bladder, utilized a mechanical lift for transfers, had no current skin break down, no history of break down and was on a repositioning schedule. Review of the Tissue Tolerance test for chair form done on 11/7/13, identified R23 was not independent in mobility/positioning and the form indicated a every two to two and one half hour repositioning schedule should be used. Review of the Braden Scale for Predicting Pressure Sore Risk dated 11/1/13, identified R23	F 314		

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F 314	Continued From page 19 had only slightly limited ability to change and control body position, was chairfast, and identified R23 was at low risk for the development of pressure ulcers. The current care plan revised 12/31/13, did not identify R23's current pressure ulcer, the increased risk for development of further pressure ulcers. The care plan identified R23 made only minor repositioning movements independently. The care plan listed various interventions which included weight distribution mattress, a therapeutic wheelchair cushion and was on a every two hour repositioning schedule. Review of R23's nursing progress notes revealed the following: On 11/28/14, a four centimeter (cm) by two cm scabbed area on coccyx with clear drainage was noted. The note indicated staff had been monitoring this and putting corona on the area. An op site (clear occlusive dressing) was applied due to the drainage at the site. On 1/10 14, an open area to R23's coccyx was again identified, with duoderm (a dressing used to promote healing for wounds) applied. The area was measured to be one centimeter (cm), with instructions noted to check the area daily and change the duoderm every three days until resolved. On 1/13/14, R23's coccyx remained open, with another duoderm applied. During an observation on 1/23/14, at 9:09 a.m. nursing assistant (NA)-C assisted R23 to stand from her wheelchair, using a mechanical lift. R23 had a securely attached four-inch square, tan colored adhesive dressing on her coccyx, with intact, pink surrounding tissue.	F 314		

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F 314	Continued From page 20 During an interview on 1/24/14, at 4:04 p.m. registered nurse (RN)-C confirmed the open area on R23's coccyx was a pressure ulcer. RN-C confirmed the usual protocol following the identification of a pressure ulcer included the following: Notify the physician, seek orders, begin more frequent repositioning, and begin reassessments for tissue profusion and skin breakdown risk immediately. RN-C confirmed that none of these things had been done for R23. She also confirmed no ongoing monitoring or measuring of the pressure ulcer had been done. RN-C stated she was not sure if the scabbed area on coccyx had healed or if the open area on coccyx noted on 1/10/14 was the same pressure ulcer. During an interview on 1/24/14, at 4:15 p.m. the director of nursing (DON) confirmed R23's skin integrity impairment on her coccyx should have been treated as a pressure ulcer. The DON confirmed no further assessments had been done since the quarterly review and stated a comprehensive assessment should have been completed at the time the scabbed area developed on R23 coccyx. The facility's undated Pressure Ulcer / Skin integrity / Wound Management policy directed each existing pressure ulcer was to be identified, with assessment of specific factors that may have influenced its development, affect healing of the pressure ulcer, or increase the risk for development of additional ulcers. The policy further instructed that these findings were to be included in the resident's care plan.	F 314		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=E	Continued From page 21 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to thoroughly investigate and implement interventions for 1 of 4 residents (R18) reviewed for falls, and failed to assess 1 of 1 resident (R18), for the safe use of padded side rails. In addition the facility failed to ensure the fireside dining room was an environment free from accident hazards, related to sharp table edges. This had the potential to affect 3 of 12 cognitively impaired residents (R23, R45 and R20) who wandered near the fireside dining room. Findings include: R18 had a history of falls, without documented evidence of an investigation or interventions initiated, following an unwitnessed fall. R18's annual Minimum Data Set (MDS) dated 5/31/13, revealed diagnoses including dementia, delirium, congestive heart failure, and incontinence. The MDS identified R18 had a severe cognitive impairment and had difficulty maintaining balance while sitting and during transfers. R18's current care plan revised	F 323	

F323

- No injuries occurred due to noted rough edges of table.
- The facility immediately removed sited tables and replaced them.
- Any resident who is noted to have a fall will have an incident report completed and immediate intervention to prevent further falls put into place.
- Staff will be re-educated the reporting procedure for environmental hazards. Education on resident fall is any change of surface and that Incident Report must be filled out and an intervention to prevent further falls must be put in place.
- Resident # 18 has had an IDT review for the use of padded side rails. It has been removed and a new pad was assessed as safe ion the wall.
- IDT will review falls daily at stand up to assure a new intervention takes place. IDT will review any new adaptive equipment put into place for safety prior to implementing a new device.
- DON/Designee will audit falls discussed at IDT to assure intervention is in place.
- Maintenance will audit table safety weekly for three months and then randomly.
- QAA will review audits for three months to review for.
- Completion date by: 3/5/14

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F 323	Continued From page 22 1/21/14, indicated R18 was at risk for falls and required the use of a mechanical, full-body lift for transfers. A nursing progress note dated 1/18/14, at 2:14 a.m. identified R18 was found with the upper part of her body on the floor and the lower half of her body on the bed. A second note dated 1/18/14, at 2:08 p.m. indicated no problems had been noted in relation to R18 having been found with her upper body on the floor that morning. No further documentation regarding this fall was found in review of R18's medical record. During interview on 1/24/14, at 2:33 p.m. registered nurse (RN)-C could not confirm that R18's upper body, having been found on the floor, was considered a fall. RN-C stated she instead, considered it "a near miss." During interview on 1/24/14, at 3:15 p.m. the director of nursing (DON) confirmed R18's upper body having been found on the floor, should have been considered a fall. The DON stated staff should have followed the protocol for post-falls, which included an immediate intervention for safety. The DON confirmed the facility's procedure after a resident fell was as follows: The staff on duty at the time of the fall were to collect all data; possible causes for the fall, vital signs, injury assessment, and an incident report/ Post Fall Form were to be completed, followed by notification of the residents' family, the administrator, the DON, and the physician. The following day the interdisciplinary team (IDT) was to review the findings and often therapy would evaluate the resident. The DON confirmed no documentation of follow-up for R18's fall on 1/18/14, had been completed.	F 323		

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F 323	Continued From page 23 R18's bed was equipped with a two-piece, padded side rail, without assessment to ensure the device was safe, appropriate and effective for her. During observation on 1/23/14, from 7:03 a.m. to 7:10 a.m. R18 was lying in bed with a full-body lift sheet beneath her. R18's bed was in a low position, with a fall matt on the floor next to the bed and a padded side rail mounted to the opposite side of her bed, along one of the walls of her room. The padded side rail was noted as two, separate pieces, mounted close together, with each piece similar in size to a quarter-rail. The padded side rail was raised, in the up position. R18 was noted to roll her upper body slightly side-to-side. At 1:22 p.m. R18 was lying on her left side, facing the padded side rails, with a pillow placed under the fitted sheet on the outer edge of the bed. The padded side rail was again noted in the up position. Review of R18's medical record lacked a side rail safety assessment, or an assessment of the appropriateness and effectiveness of the padded side rail for R18. During interview on 1/24/14, at 2:33 p.m. RN-C confirmed R18 had padded side rails mounted on the wall-side of her bed. RN-C stated the usual protocol following placement of a physical device on a bed was to complete an assessment for safety and effectiveness. RN-C stated that therapy was then to review the device and make a note regarding the devices use. RN-C confirmed no documentation was found in R18's medical record of an assessment for placement of padded side rails to her bed.	F 323		

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F 323	Continued From page 24 During interview on 1/24/14, at 3:15 p.m. the director of nursing (DON) confirmed the adaptive device mounted to R18's bed should have been assessed, to evaluate the effectiveness and R18's safety with use of the padded side rail. The DON stated all things added to a bed were to be assessed for safety, including concave mattress, air mattress and padded side rails. The DON confirmed she expected an initial assessment of all bed additions, for safety and effectiveness, and a review of the assessment was to be completed at least quarterly. The DON confirmed no documentation was found in R18's medical record of an assessment for placement of padded side rails to her bed. The facility lacked a plan to prevent injury from exposed, sharp edges of laminate on a fireside dining room table, for R23, R45 and R20, who were cognitively impaired and had a history of wandering. R23's annual MDS dated 8/23/13, identified the resident as severely cognitively impaired. The MDS further identified R23 wandered in the facility with the potential for intruding on others' privacy or placing the resident in a dangerous place. R45's quarterly MDS dated 11/7/13, identified R45 was severely cognitively impaired and wandered in the facility daily. R20's annual MDS dated 6/28/13, identified the resident as moderately cognitively impaired with disorganized thinking and poor decision making skills. The MDS further identified R20 wandered in the facility and required supervision.	F 323		

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F 323	Continued From page 25 On 1/21/14, the following was observed: At 2:04 p.m., in the facility fireside resident dining room and lounge, there were three round dining tables. The table closest to the galley had an irregular area of exposed wood, where the thin laminate had been ripped off the edge and top of the table. The area of laminate had exposed, sharp edges, and on one side of the area, the laminate was partially curled up from the top and edge of the table. The curled part of the laminate also had sharp, irregular edges. There were six residents present in the dining room at the time of this observation. At 4:14 p.m., in the fireside dining room, the same table with the ripped laminate area was present. R23 was seated at the table noted above, slightly to the right of the exposed area. R45 was walking independently in fireside dining room near the tables. R45 opened a door to a facility treatment room, walked next to the table in the dining room and asked staff for the location of his walker. At 4:29 p.m., R20 was seated in a wheelchair and wheeled back and forth in front of the fireside dining room, near the table noted above. R20 called out, "hey, hey, hey, come on, come on." R20 was unable to state what he needed when asked. At 4:29 p.m., the facility dietary manager (DD) entered the fireside dining room and placed a beige tablecloth over the marred table, as dietary aide (DA)-B washed the other two tables in the dining room and placed beige table cloths over them.	F 323		

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F 323	Continued From page 26 At 5:54 p.m., after the supper meal, DA-B began removing dishware and tablecloths from all three tables, the table with the curled laminate remained uncovered. On 1/21/14, at 4:32 p.m., DA-B stated the tablecloths were placed on the dining tables immediately before meals and were removed immediately after meals. DA-B confirmed the exposed area and sharp edges on the laminate, and stated it had been present, "for a few weeks." DA-B stated R23 picks off the laminate. On 1/21/14, at 6:09 p.m., RN-D confirmed the exposed area and sharp edges of laminate on the table. RN-D stated the area had been there "for about two weeks," the DD was aware of the area, and was not sure what the plan was for repair. RN-D stated nothing was done differently at the time and was unaware if any resident had been injured on the table recently. On 1/21/14, at 6:21 p.m., licensed practical nurse (LPN)-C stated the tables in the fireside dining room were usually bare for the evening meal and not covered with a tablecloth. Review of R23's progress notes revealed on 12/28/13, identifed R23 was noted to be peeling the vinyl off of the tables in the main dining room and in the fireside lounge. On 1/21/14, at 6:23 p.m., DD stated the exposed and marred area on the table with sharp laminate edges, had been present for approximately two weeks. DD indicated R23 would shred the laminate and stated the facility maintenance department was aware of the area and had not come up with a plan to fix the area. DD confirmed	F 323		

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F 323	Continued From page 27 the sharp edges and measured the area at 7.5 by 2.5 inches (in) on the top of the table and 3.5 in on the edge. DD confirmed table cloths had not been utilized at the evening meal until the surveyor had questions about the area. DD stated she was not aware of any resident injury related to the sharp laminate edges. DD stated the area had been increasing, and R23 "shredded" it and would shred other things as well. On 1/21/14, at 6:26 p.m., DON confirmed the presence of the sharp laminate on the dining table and stated she was aware it had been present for a couple of weeks, however, "I wasn't aware it was that sharp." DON confirmed the sharp edges could cause injury and stated R23 had shredded the laminate before on another facility table. DON stated she was not aware of any injury related to the table. However there were no plans to remove the table or to keep R23, who was usually seated at the table, or any other wandering residents, safe from injury. An undated Accidents/Falls policy indicated the facility promoted safety, dignity, and overall quality of life for its residents by providing an environment that was free from any hazards for which the facility had control and by providing appropriate supervision and interventions to prevent avoidable accidents.	F 323		
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	F 329		

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F 329	Continued From page 28 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement individualized target behavior monitoring on an on-going basis to justify the continued use of psychoactive medication and failed to adequately monitor non-pharmacological interventions attempted, in order to evaluate the effectiveness of those interventions, for 1 of 1 residents (R34) in the sample who received antipsychotic medication. Findings include: R34's annual Minimum Data Set (MDS) dated 11/14/14, revealed diagnoses including Alzheimer	F 329	• Resident #34 has had pharmacy review his antipsychotic medication use and targeted behaviors listed for the use of his Zyprexa use. • Facility has implemented a new targeted behavior sheet with resident specific behaviors and non pharmacological interventions in place for residents on antipsychotic medication.. • LN/NAR's have received education on using new system to assure residents' targeted behaviors are in place and that documentation will occur. • Nurse Managers will audit sheets weekly to assure staff are properly documenting targeted behaviors for residents receiving antipsychotic medication.. • QA will review audits for three months to review for. • Completion date by: 3/5/14	

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F 329	Continued From page 29 disease, unspecified psychosis, dementia with behavioral disturbances and senile dementia with delusional features. The MDS also identified R34 had a severe cognitive impairment, difficulty maintaining attention and disorganized thinking. R34's current physician orders dated 1/14, included Zyprexa (antipsychotic) 25 milligrams (mg) at bed time, for dementia with behavioral disturbances. R34's care plan dated 1/24/14, identified behavior concerns including the following: Verbally abusive toward staff, primarily during direct cares; History of anxiety and frequent repetitive comments/questions; History of insomnia; Manipulative behavior, playing one person against the other and false accusations against staff; History of spitting on the floors of the halls, dining room, Fireside lounge and family room. Interventions included the following: Providing R34 with a spit container, placing a half table on his wheelchair so he was able to set the spit container on the table; Watching for behavior of entering other resident's rooms, redirecting and reorienting him to his own room when he entered the wrong room; Diverting his thought processes when he made false accusations; and Administering psychotropic medications per his physician orders, monitoring for any adverse reactions to the medication. Observations on 1/21/14, from 5:36 p.m. to 5:51 p.m. and on 1/23/14, from 7:14 a.m. to 10:01 a.m. revealed behavior concerns including leaning over and spitting food onto the floor and pounding his cup on the table during meal times, repeatedly yelling "Come on," wandering into another resident's room, and calling out for his wife.	F 329		

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F 329	Continued From page 30 Interventions attempted by facility employees included redirection/ instruction, providing food/ beverage, and physically wheeling him out of other residents' rooms when he wandered into them. The interventions observed were mildly effective and short-lived. During interview on 1/23/14, at 1:40 p.m. nursing assistant (NA)-D said R34 spit on the floor at every meal, but NA-D and other facility staff could not figure out why. NA-D said they tried a spit cup, but R34 usually tucked it in his shirt, and he refused to use the half tray on his wheelchair. R34's behavior monitoring sheets were reviewed from 11/8/13, to 1/23/14, and revealed the following: · The target behaviors identified included wandering, verbally abusive symptoms, physically abusive symptoms, socially inappropriate/ disruptive symptoms and resists care. Behaviors repeatedly documented by staff included exposing private parts, spitting on the floor, resistance to care, yelling and banging his call light on his bed. The target behaviors identified where not individualized to be consistent with the behavior concerns that were documented by staff. · R34's behaviors were not consistently documented, on an on-going basis. · Documentation lacked notation of non-pharmacological interventions attempted in response to his target behaviors and the effectiveness of those interventions. Review of R34's progress notes from 10/24/13, to 1/16/14, indicated target behaviors were present, but aside from a note on 1/6/14, lacked non-pharmacological interventions attempted and	F 329		

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F 329	Continued From page 31	F 329		

the effectiveness of those interventions. On 1/6/14, R34 was noted to spit on the floor. The non-pharmacological intervention attempted was to give him a cup to set on his half tray table, which was attached to his wheelchair. R34 was also instructed to spit in the cup if he felt the need to spit. The note added, R34 refused to use the cup and moved the tray to the side, continuing to spit.

Review of R34's medical record revealed no further documentation of non-pharmacological interventions that were implemented and the effectiveness of those interventions.

During interview on 1/24/13, at 2:09 p.m. registered nurse (RN)-A confirmed the behavior monitoring for R34. She confirmed the current facility policy and stated the facility had changed their behavior monitoring forms in the past because they had not been gathering enough information for behavior monitoring. She confirmed the current forms did not include the non pharmacological interventions utilized for the target behavior and did not include the effectiveness of those interventions. She indicated the current behavior monitoring forms only tracked what behaviors were observed by the staff.

Interview on 1/31/14, at approximately 2:45 p.m. the consulting pharmacist said her expectation was to monitor a resident's target behaviors and to utilize non-pharmacological interventions. The consulting pharmacist reported she was unaware of the facility's system for monitoring target behaviors.

The facility's Unnecessary Drugs-Antipsychotic

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F 329	Continued From page 32 policy dated 4/09, indicated there needed to be specific reasons why a medication was to be given. All target behaviors were to be quantitatively and objectively documented in each resident's record. The policy added, monitoring for effectiveness or the side effects of medications and the non-pharmaceutical interventions that were tried prior to the use of the medication were also to be documented.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356	**F356** The facility has developed a new format on which to post the required hours worked for each category of nursing staff. • Staff will be educated in the proper way in which to complete the form and update with changes in staffing related to call ins or other changes. • DON/Designee will audit weekly to assure staffing sheet is correct format and hours. QAA will review audits for three months to review for trends. • Completion date by: 3/5/2014	

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F 356	Continued From page 33 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the required daily nurse staffing posting included the actual hours worked, for each shift, separated by licensed and unlicensed staff. This had the potential to affect all 47 of 47 residents who currently resided in the facility, as well as family members or the general public who may have wished to review this information. Findings Include: During the initial tour on 1/21/14, at 2:00 p.m., the facility's Daily Staff Posting was observed on the wall near the nurse's station. The posting was dated Tuesday, 1/21/14. The posting lacked the actual hours worked for each individual shift. The daily staff posting also lacked the actual shift hours worked by licensed and unlicensed staff responsible for providing direct resident care. Review of Daily Staffing Postings from 12/21/13, to 1/24/14, revealed the usual shifts licensed and unlicensed staff were scheduled to work, but did not identify the actual hours worked. During interview on 1/24/14, at 2:18 p.m., director of nursing (DON) verified the Daily Staff Posting information was incorrect and lacked the posting of actual hours worked by each category. The Nurse Staffing-Required Posting policy dated	F 356		

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F 356	Continued From page 34 4/1/08, indicated that a total number of hours worked and the actual hours worked were to be listed on the daily staffing posting, which included registered nurses, licensed nurses and nursing assistants that were responsible for direct resident care.	F 356		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consulting pharmacist failed to identify the facility's behavior monitoring practices, for 1 of 1 residents (R34) reviewed for antipsychotic medication use, lacked individualized target behavior monitoring on an on-going basis, monitoring of non-pharmacological interventions attempted, and evaluation of intervention efficacy. Findings include: R34's current physician orders dated 1/14, included Zyprexa (antipsychotic) 25 milligrams (mg) at bed time, for dementia with behavioral	F 428	**F428** • Resident #34 has been reviewed by consultant pharmacist related to his targeted behaviors. • Consultant pharmacist has been educated on facilities targeted behavior monitoring system and will review residents in facility on antipsychotic medication monthly to assure facility is utilizing non pharmacological interventions and effectiveness of medications. • DON/Designee will audit consultant pharmacist reports monthly to assure consultant pharmacist has reviewed targeted behaviors per facility system. QA will review audits for three months to review for trends. • Completion date by: 3/5/14	

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F 428	Continued From page 35 disturbances. R34's care plan dated 1/24/14, identified behavior concerns including the following: Verbally abusive toward staff, primarily during direct cares; History of anxiety and frequent repetitive comments/questions; History of insomnia; Manipulative behavior, playing one person against the other and false accusations against staff; History of spitting on the floors of the halls, dining room, Fireside lounge and family room. Interventions included the following: Providing R34 with a spit container, placing a half table on his wheelchair so he was able to set the spit container on the table; Watching for behavior of entering other resident's rooms, redirecting and reorienting him to his own room when he entered the wrong room; Diverting his thought processes when he made false accusations; and Administering psychotropic medications per his physician orders, monitoring for any adverse reactions to the medication. R34's behavior monitoring sheets were reviewed from 11/8/13, to 1/23/14, and revealed the following: · The target behaviors identified included wandering, verbally abusive symptoms, physically abusive symptoms, socially inappropriate/ disruptive symptoms and resists care. Behaviors repeatedly documented by staff included exposing private parts, spitting on the floor, resistance to care, yelling and banging his call light on his bed. The target behaviors identified where not individualized to be consistent with the behavior concerns that were documented by staff. · R34's behaviors were not consistently documented, on an on-going basis.	F 428		

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F 428	Continued From page 36 · Documentation lacked notation of non-pharmacological interventions attempted in response to his target behaviors and the effectiveness of those interventions. Review of R34's progress notes from 10/24/13, to 1/16/14, indicated target behaviors were present, but aside from a note on 1/6/14, lacked non-pharmacological interventions attempted and the effectiveness of those interventions. On 1/6/14, R34 was noted to spit on the floor. The non-pharmacological intervention attempted was to give him a cup to set on his half tray table, which was attached to his wheelchair. R34 was also instructed to spit in the cup if he felt the need to spit. The note added, R34 refused to use the cup and moved the tray to the side, continuing to spit. Review of R34's Pharmacist's Monthly Drug Regimen Review Form from 8/6/13 to 1/7/14 revealed the monthly reviews had been documented as "ok" with the exception of the 12/4/13 review. On 12/4/13, the consulting pharmacist had faxed a pharmacist report to the physician which indicated R34 received Zyprexa 2.5 mg daily and requested consideration to decrease or hold the dose of the medication. Interview on 1/31/14, at approximately 2:45 p.m. the consulting pharmacist confirmed she conducted monthly medication reviews for all residents in the facility. She stated her expectation was to monitor a resident's target behavior and to utilize non-pharmacological interventions. The consulting pharmacist reported she was unaware of the facility's system for monitoring target behaviors.	F 428		

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F 428	Continued From page 37 The facility's Unnecessary Drugs-Antipsychotic policy dated 4/09, indicated there needed to be specific reasons why a medication was to be given. All target behaviors were to be quantitatively and objectively documented in each resident's record. The policy added, monitoring for effectiveness or the side effects of medications and the non-pharmaceutical interventions that were tried prior to the use of the medication were also to be documented.	F 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441	**F441** Facility will implement infection control practices to prevent cross contamination. • Staff has been educated on infection control standards for handling soiled linens. • DON/Designee will complete weekly audits to assure staff is properly handling soiled linen to prevent contamination. • QAA will review audits for three months to review for trends. • Completion date by: 3/5/2014	

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F 441	Continued From page 38 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement infection control practices for soiled linens and personal hygiene items, to minimize the risk for cross contamination. This had the potential to affect 4 of 4 residents (R48, R25, R23 and R13), observed with shared bathrooms. Findings include: R48's bedside table and the counter of his bathroom shared with R25 were exposed to soiled linens, with the potential for cross contamination of infectious disease. During observation on 1/23/14, at 8:15 a.m. nursing assistant (NA)-A provided routine morning cares for R48 in his resident room. NA-A completed his perineal cares while R48 was lying in bed. NA-A first used a wet washcloth to wash the front and back of R48's perineal area. A small amount of bowel movement was noted on the washcloth. NA-A then used a dry towel to dry the entire area. Immediately after providing R48's perineal cares, NA-A placed the soiled washcloth	F 441		

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F 441	Continued From page 39 and towel on the table, next to R48's bed. NA-A finished dressing R48, assisted him to the bathroom and onto the toilet. NA-A then went into R48's bedroom, grabbed the soiled cloths from the table and brought them into the bathroom, placing the soiled cloths directly onto the bathroom counter. After which, NA-A grabbed a plastic bag and put the soiled cloths into the bag. NA-A confirmed that she had completed R48's cares. NA-A did not disinfect the table or bathroom counter after collecting the dirty cloths. During interview on 1/23/14, at 8:50 a.m. NA-A confirmed the towel and washcloth that she placed on R48's table and bathroom counter were used for cleaning R48's perineal area. NA-A also confirmed that R48 shared a bathroom with R25. NA-A stated that her usual practice was to place soiled cloths on tables, counters or in a bag, but not on the floor. During interview on 1/24/14, at 3:41 p.m. the director of nursing (DON) stated that staff were expected to place washcloths and towels that had been used to clean perineal areas, directly into a bag to be taken to laundry. The DON confirmed that it was not acceptable to place soiled cloths on tables and counters. The facility's Linen Handling Policy dated 2008, directed staff to use procedures designed to prevent the spread of infection. The facility comingled resident personal care items for R23 and R13, resulting in the potential for cross contamination of infectious disease. During observation on 1/23/14, at 7:14 a.m. a sink-top in the shared resident bathroom of R23 and R13 was cluttered with personal toiletries	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	01/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

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F 441	Continued From page 40 belonging to both residents, including perineal wash and lotion. Also among the toiletries was a plastic basin, labeled with R23's name and lined with a paper towel. The basin contained a tube of toothpaste and a white toothbrush. The basin was located directly under the soap dispenser. During R13's morning cares, NA-C was observed to use the shared bathroom sink to wash her hands and to wet washcloths. NA-C then removed R13's brief and placed her on the toilet, after which NA-C removed the soiled gloves and applied soap to her hands, using the soap dispenser noted as two inches above R23's oral care basin. NA-C then washed her hands under running water, which was noted as four inches from R23's oral care basin. NA-C donned new gloves, applied a perineal wash (which was among the cluttered toiletries) to a washcloth and completed perineal cares for R13. After NA-C disposed of the soiled linens and incontinent products, she removed the soiled gloves, applied soap to her hands from the wall mounted soap dispenser and washed her hands again, inches away from R23's exposed toothbrush. During interview on 1/23/14, at 7:32 a.m. NA-C confirmed the white toothbrush in the plastic basin, was the toothbrush she had used earlier that morning to brush R23's teeth. NA-C confirmed R23's toothbrush was routinely kept uncovered, to the left of the sink, under the soap dispenser. NA-C confirmed her understanding of the potential for cross contamination with personal use items left on the sink top. During interview on 1/24/14, at 2:14 p.m. registered nurse (RN)-C confirmed personal items including toothbrushes were to be stored away from shared use areas, to prevent cross	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	01/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

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F 441	Continued From page 41 contamination. During interview on 1/24/14, at 3:20 p.m. the director of nursing (DON) confirmed she expected each resident to have individual products for personal care use. The items were to be labeled and separated to prevent cross contamination. A facility Infection Control policy dated 4/1/08, identified infection control practices were used to prevent the development and transmission of disease.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a functioning call light for 1 of 30 residents (R37) observed during stage one. Findings include: The facility lacked a procedure for ensuring the function of resident call lights. R37's annual Minimum Data Set (MDS) dated 11/28/13, identified R37 had moderately intact cognition. The MDS further identified R37 required assistance of facility staff with activities of daily living, which included assistance to dress,	F 463	**F463** • Resident # 37 immediately had call light replaced. All call lights checked house wide and were in working order. • Maintenance will check call lights weekly X 3 months to assure they are in working order and then random audits thereafter to assure call lights are in working . • Maintenance Director will record findings from audits and review monthly at QAA x 3mos. • Completion date by: 3/5/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	01/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 463	Continued From page 42 bathe, brush teeth and walk in the hallway with a walker. On 1/24/14, at 9:37 a.m., a facility tour was performed with the maintenance director (MD). The resident call light in R37's room was not functional. When inquiry was made as to how the facility would know there was a non-functioning resident call light, MD stated if facility staff identified a resident call light that was not functional, the maintenance department would be notified immediately for repair. However, MD stated he was not aware the light did not function, or how long it had been non-functional. MD confirmed there was not a facility procedure for auditing the function of resident call lights. MD indicated he would expect each resident to have a functioning call light in order to notify staff if there was needed assistance. A facility policy for of the resident call system was requested, however none was provided.	F 463		
F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide adequate space to enhance the	F 464	**F464D** • Dining room has been arranged to assure residents have sufficient space to enhance their dining enjoyment. • Dietary Manager or designee will audit DR 2x weekly for 3 mos to assure DR remains with an atmosphere to assure proper dining atmosphere. • QA will review audits for three months to review for trends. • Completion date by: 3/5/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	01/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

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F 464	Continued From page 43 dining experience during 2 of 2 meal observations in the fireside dining room, for (R31, R34, R20 and R18). This had the potential to affect 12 of 12 residents who ate in the Fireside dining room. Findings include: Observations of the evening meal on 1/21/14, at 5:24 p.m. revealed the fireside dining room had seating capacity for 12 residents. There were three round tables that seated four residents, each. The three tables had been placed in a row, with little room between the tables. Nursing assistant (NA)-D had to move R31 to the left, in order to have room to sit between R31 and R34 to provide eating assistance. At 5:44 p.m., R31 had rolled back in his wheelchair and sat partly away from the dining table, while R20 sat at an angle to the table in his wheelchair. A female staff person propelled a male resident through the dining area, which was the walkway between the dining tables and the nurse's desk. R31 had to be moved closer to the table by staff, in order for the staff to propel the resident through the dining area to the 300 and 400 wing of the facility. At 5:45 p.m., licensed practical nurse (LPN)-D had to move a stationary chair away from an adjacent dining table, in order to have room to move R18 away from her dining table in her wheelchair after she had completed her meal. During an observation of the lunch meal on 1/23/14, at 12:03 p.m. the activities director (AD) propelled a female resident in her wheelchair, away from the fireside dining area. As this resident was propelled away from the dining area, her wheelchair bumped the back of a male residents wheelchair who was seated at 1 of the	F 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING _____ B. WING _____	01/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	303 SEVENTH STREET SOUTH WHEATON, MN 56296

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F 464	Continued From page 44 3 dining tables. During an interview on 1/21/14, 5:48 p.m. NA-E confirmed 12 residents routinely utilized the fireside dining room for the lunch and dinner meals daily, with four residents seated at each of the three tables. NA-E confirmed that residents routinely needed to be moved in order to move other residents to and from the dining tables. NA-E stated sometimes "it is much worse," it depended on how active residents were. During an interview on 1/21/14, at 7:20 p.m. NA-D confirmed she had moved residents in wheelchairs numerous times during this dinner meal in order to move other residents to and from the tables. NA-D stated "yes it gets a little tight," the tables were small for four people to fit around them and then the wheelchairs were big. During an interview on 1/23/14, at 12:07 p.m. the AD confirmed bumping the back of a male resident's wheelchair as she propelled another resident from the fireside dining area. AD also confirmed the dining area was a tight fit for the residents served, and it was difficult to propel other residents through the area to the main dining room.	F 464		

2-25-14

Addendum to the plan of correction for survey exiting on 1-24-14.

F225: QA to audit daily reports.
Will review daily, the progress notes, looking for reportable incidents and will investigate allegations of mistreatment.

F226: QA to audit daily reports.
Will review daily, the progress notes, looking for reportable incidents and will investigate allegations of mistreatment.

F314: Will review the sited people that are at risk for pressure ulcers immediately as well as the residents that are determined to be at a high risk for pressure ulcers, and the rest of the residents on their ARD date for pressure ulcer risk, so we can have a continuous quarterly rotation.

Will review assessments for accuracy, and Nurse Manager will audit charts for residents at risk for Comprehensive assessments and for on-going implementation of interventions.

F323: In both dining rooms the table tops will be audited for rough edges weekly x's 3 months.

Nurse Manager will review physical device assessments for anyone with side rails or assistive devices and will complete assessments as needed.

F329: All current residents and newly admitted residents that are on anti-psychotic medications will be reviewed for individual target behaviors and monitoring for non-pharmaceutical interventions and effectiveness.

F428: All current residents and newly admitted residents that are on anti-psychotic medications will be reviewed for individual target behaviors and monitoring for non-pharmaceutical interventions and effectiveness.

F441: Staff has been educated on Infection Control Practices and cross contamination.

A team of 3 staff have been developed to clean bath room counters and put all the residents personal belongings in individual baskets, the baskets will be stored on the top of the resident's dresser in their closet.

Small laundry baskets will be in each of the resident's bath rooms and the night staff will be bagging the laundry and bringing to the laundry room during the night.

Audits for the bath room counters being clear will be done weekly x's 3 months.

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

F5585023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/22/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRAVERSE CARE CENTER	**303 SEVENTH STREET SOUTH WHEATON, MN 56296**

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Traverse Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

This facility was surveyed as two buildings due to the construction dates of the buildings. The original building (Bldg. 1)
was constructed in 1967 and was determined to be of at least Type II(111) construction. It is 1 story with partial basement and is fully protected with fire sprinklers. This building consists of the 100, 200 and 600 Wings and was surveyed to Chapter 19 Existing Health Care. The facility has a fire alarm system that is monitored for automatic fire department notification and smoke detectors in all resident rooms, areas open to the corridors as well as by barrier doors held open with magnetic hold-openers. The facility has a capacity of 50 beds and had a census of 47 at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is MET.

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

F5585023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245585	A. BUILDING **02 - 2ND BUILDING** B. WING _____	**01/22/2014**

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Traverse Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care.

This facility was surveyed as two buildings due to the construction dates of the buildings. Building 2 was constructed in 2005 and was determined to be of Type V(111) construction. It is 1 story with no basement and is fully protected with fire sprinklers. This building consists of the 300, 400 and 500 Wings. and was surveyed to Chaper 18 New Health Care. The facility has a fire alarm system that is monitored for automatic fire department notification and smoke detectors in all resident rooms, areas open to the corridors as well as by barrier doors held open with magnetic hold-openers. The facility has a capacity of 50 beds and had a census of 47 at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is MET.

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8156

February 10, 2014

Ms. Chelsey Stattleman, Administrator
Traverse Care Center
303 Seventh Street South
Wheaton, Minnesota 56296

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5585024

Dear Ms. Stattleman:

The above facility was surveyed on January 21, 2014 through January 24, 2014 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, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

When all orders are corrected, the order form should be signed and returned to:

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537-3858

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

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697
Enclosure(s)

cc: Original - Facility
Licensing and Certification File