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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: TLIV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00619

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245473**

2.STATE VENDOR OR MEDICAID NO.
(L2) **747642000**

3. NAME AND ADDRESS OF FACILITY
(L3) **OAK TERRACE HEALTH CARE CENTER**
(L4) **640 THIRD STREET**
(L5) **GAYLORD, MN** (L6) **55334**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/20/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **46** (L18)

13.Total Certified Beds **46** (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
	46			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Jessica Sellner, Unit Supervisor — 01/20/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 02/03/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 02/17/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/31/2015
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245473
February 3, 2016

Ms. Deborah Barnes, Administrator
Oak Terrace Health Care Center
640 Third Street
Gaylord, Minnesota 55334

Dear Ms. Barnes:

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 December 21, 2015 the above facility is certified for or recommended for:

46 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 46 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 3, 2016

Ms. Deborah Barnes, Administrator
Oak Terrace Health Care Center
640 Third Street
Gaylord, Minnesota 55334

RE: Project Number S5473026

Dear Ms. Barnes:

On December 17, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 3, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 20, 2016, 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 December 3, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 21, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 3, 2015, effective December 21, 2015 and therefore remedies outlined in our letter to you dated December 17, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245473 Y1	A. Building B. Wing Y2	1/20/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	640 THIRD STREET GAYLORD, MN 55334

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156	Correction	ID Prefix F0157	Correction	ID Prefix F0246	Correction
Reg. # 483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. # 483.10(b)(11)	Completed	Reg. # 483.15(e)(1)	Completed
LSC	12/05/2015	LSC	12/05/2015	LSC	12/21/2015
ID Prefix F0309	Correction	ID Prefix F0311	Correction	ID Prefix F0313	Correction
Reg. # 483.25	Completed	Reg. # 483.25(a)(2)	Completed	Reg. # 483.25(b)	Completed
LSC	12/21/2015	LSC	12/18/2015	LSC	12/18/2015
ID Prefix F0315	Correction	ID Prefix F0323	Correction	ID Prefix F0328	Correction
Reg. # 483.25(d)	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.25(k)	Completed
LSC	12/18/2015	LSC	12/04/2015	LSC	12/18/2015
ID Prefix F0412	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.55(b)	Completed	Reg. # 483.65	Completed	Reg. #	Completed
LSC	12/18/2015	LSC	12/21/2015	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	JS/KJ	02/03/2016	29249	01/20/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
12/3/2015

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: TLIV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00619

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(L1) **245473**

2.STATE VENDOR OR MEDICAID NO.
(L2) **747642000**

3. NAME AND ADDRESS OF FACILITY
(L3) **OAK TERRACE HEALTH CARE CENTER**
(L4) **640 THIRD STREET**
(L5) **GAYLORD, MN** (L6) **55334**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/03/2015** (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 **46** (L18)

13.Total Certified Beds **46** (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
	46			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mary Rogers, HPR Social Work Specialist 12/23/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 12/31/2015 (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
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/31/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

Electronically delivered
December 17, 2015

Ms. Deborah Barnes, Administrator
Oak Terrace Health Care Center
640 Third Street
Gaylord, Minnesota 55334

RE: Project Number S5473026

Dear Ms. Barnes:

On December 3, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

Informal Dispute Resolution - 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:

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
Health Regulation Division
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

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 January 12, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 12, 2016 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 3, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 3, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Tom Linhoff, Interim Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	640 THIRD STREET GAYLORD, MN 55334

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		12/5/15

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

Electronically Signed | 12/21/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING _____ B. WING _____	12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	**640 THIRD STREET GAYLORD, MN 55334**

(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 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure required notices were provided for 2 of 2 residents (R57 and R29) who discharged from the facility upon termination of Medicare covered services. The facility also failed to ensure a Notice of Medicare Non-Coverage was provided at least two days prior to services ending for 1 of 3 residents (R81) who remained in the facility after Medicare covered services ended and therapy goals were met. Findings include: R57's Physical Therapy Evaluation/ Discharge Summary dated 9/25/15, and Occupational Therapy Evaluation/ Discharge Summary dated 9/25/15, identified the resident received Medicare	F 156	This plan and the individual responses to each F-tag area written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute and admission of noncompliance with any requirement. We wish to preserve our right to dispute these findings in their entirety in any legal or administrative proceeding. F 156 E The thee residents (57, 29, 81) Residents 57 and 29 were discharged prior to issuing a denial, prior to benefits being terminated. Resident was issued a timely denial, per verbal issue to family, per note in chart. The DON/MDS nurse will ensure at that	

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F 156	Continued From page 3 covered physical and occupational therapies after a hospitalization for aspiration pneumonia and exacerbation of congestive heart failure. The discharge summary for physical therapy (PT) indicated R57 had reached her maximum functional potential and was being discharged from PT services on 9/25/15. The discharge summary for occupational therapy (OT) noted R57 had reached a plateau in progress and was being discharged from OT services on 9/25/15. R57's Admission Record form dated 12/3/15, identified he was not discharged from the facility until 10/16/15. R57's medical record lacked evidence to support notification of covered services ending was provided to R57, or his legal representative. During interview on 12/2/15, at 11:54 a.m. director of nursing (DON) stated no notice was provided to R57 and/or his legal representative because the resident had agreed to be discharged home, and was not being cut-off from the Medicare benefit. R29's Occupational Therapy Evaluation/ Discharge Summary dated 6/25/15, identified the resident received Medicare covered OT after a hip replacement. The discharge summary for OT identified R29 had met her goals to a level appropriate for discharge from the facility and was being discharged from in-patient OT services on 6/25/15, with continued out-patient therapies. R29's Admission Record form dated 12/3/15, identified the resident discharged from the facility on 6/26/15. R29's medical record lacked evidence to support notification of covered services ending was provided to R29, or her legal representative.	F 156	every resident will receive the appropriate liability notices of Medicare non-coverage and provide the required two day notice of non-coverage for all residents meeting the Medicare Criteria. The DON and MDS nurse will be responsible for issuing these notices; these will be issued two days prior to denial, nursing and therapy will meet daily to determine who needs a denial notice issued. Administrator will monitor process and ensure compliance. 12/5/15 DON/MDS/administrator nurse	

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During interview on 12/2/15, at 11:54 a.m. DON stated no notice of coverage ending was provided to R29 and/or her legal representative, because the resident had agreed to be discharged home and was not being cut-off from the Medicare benefit. The DON stated she and her assistant were both responsible for ensuring the required notifications for Medicare non-coverage were provided to residents in accordance with the Medicare guidelines. DON stated once she or her assistant were informed a resident would be discharged from therapy, they talked with the resident or family and let them know their Medicare coverage was going to be ending soon, and if the resident and/or their legal guardian agreed they were ready to go home, she did not believe a formal notice was necessary because the resident was not being forced off the Medicare benefit. DON stated if the resident did not say they were ready to be discharged from the facility, or did not agree to be discharged before the benefit was to end, then a written notice of coverage ending was provided at least two days prior to services ending, so they were aware of their right to appeal or if they wanted to remain in the facility with a different payer source.

R81's Physical Therapy Evaluation/ Discharge Summary dated 11/4/15, and Occupational Therapy Evaluation/ Discharge Summary dated 11/5/15, identified the resident received Medicare covered PT and OT services after a hospitalization for increased weakness, fatigue and chronic kidney disease. The discharge summary for PT noted R81 had reached her maximum functional potential and was being discharged from PT services on 11/4/15. The discharge summary for OT noted R81 had reached her maximum functional potential and

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F 156	Continued From page 5 was being discharged from OT services on 11/5/15. R81's Admission Record dated 12/3/15, identified the resident remained a current resident in the facility and was not discharged upon Medicare covered services ending. R81 was provided with a SNF (Skilled Nursing Facility) Determination of Continued Stay on 11/2/15. However, her Notice of Medicare Non-Coverage (CMS-10123) was not provided until 11/5/15, less than the required two days prior to covered services ending. During interview on 12/3/15, at 1:29 p.m. DON stated residents and/ or guardian are required to receive the notification of Medicare Non-Coverage at least two days prior to covered services ending. A policy regarding Medicare non-coverage was requested, but none was provided.	F 156		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge	F 157		12/5/15

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F 157	Continued From page 6 the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure family was notified timely for 1 of 1 residents (R16) who had been started on therapy and family was not notified. Findings include: R16's quarterly Minimum Data Set (MDS) dated 8/6/15, identified R16 had severe cognitive impairment, required supervision with transfers and locomotion, and had been seen for physical and occupational therapy services. During interview on 11/30/15, at 6:36 p.m. family member (FM)-A stated R16 had been started on therapy services a couple months prior and she had not been notified by the facility. FM-A stated she found out R16 was receiving therapy after being sent a letter by the facility identifying R16's Medicare coverage would be ending after the	F 157	F 157 R 16, family was notified of therapy being started on 8/20/15 per care conference notes by MDS nurse. Transcribing licensed nurse will ensure that designated family member will be notified of any new therapy orders received by the physician. Family notification will be evident by documentation by the transcribing nurse of a progress note in the resident's POC. MDS nurse will receive all copies of orders and ensure that family notification was completed. At weekly Medicare meeting, Medicare team will discuss all family notification in regards to start of therapy. Licensed nursing staff was re-educated on this process on 12/9/2015 by DON. 12/5/15 DON/MDS	

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F 157	Continued From page 7 therapy services were completed. FM-A stated she was unhappy about the lack of communication regarding R16 being started on therapy, and would have liked to have been notified when R16 was started on therapy services. R16's progress notes dated 7/20/15, to 8/31/15, were reviewed and identified on 7/24/15, the facility faxed R16's physician requesting orders for, "PT [physical therapy] to eval [evaluate] and treat r/t [related to] transfers and leg strengthening." A Quarterly Review Note dated 8/19/15, identified R16 was, "Currently working with PT/OT services." A subsequent progress note dated 8/20/15, identified staff mailed the Quarterly Review Note to FM-A as she was unable to attend the care conference for R16 on that date. The progress notes did not identify R16's responsible party, FM-A, had been notified of these changes in R16's care and treatment at any time. During interview on 12/3/15, at 10:22 a.m. registered nurse (RN)-A stated R16 had been picked up for skilled (Medicare) therapy services on 7/24/15, and ended those services on 8/19/15 (a total of 27 days). RN-A was unsure of if R16's responsible party (FM-A) had been notified of the change in treatment. However, after RN-A reviewed R16's medical record, she stated FM-A had been notified of the therapy services when she was mailed the Quarterly Review Note and Medicare non-coverage notices, which was dated 8/19/15, 26 days after the therapy had begun. RN-A stated she could not find any further documentation to identify FM-A had been notified of R16's therapy services until after therapy had been completed.	F 157	12/22/15 MDS/SW	

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F 157	Continued From page 8 During interview on 12/3/15, at 10:51 a.m. occupational therapist (OT)-A stated she reviewed R16's record with RN-A and was unable to locate any documentation FM-A had been notified of the start of therapy services for R16. OT-A stated therapy had no contact with R16's family regarding therapy, and understood that nursing staff noticed a change in R16's status and requested orders for therapy services, which would be considered a significant change in treatment, and the facility would be contacting family to ensure they were updated with therapy service changes. During interview on 12/3/15, at 10:57 a.m. director of nursing (DON) stated FM-A should have been notified of the start of therapy services for R16 by the nursing staff, and the facility had no established policy or procedure to ensure families were notified of changes in treatments.	F 157		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and develop interventions to promote	F 246	F 246: Accommodation of needs Dietary Manager interviewed resident and addressed in care plan that resident is	12/21/15

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F 246	Continued From page 9 independence with eating for 1 of 1 residents (R18) observed to put the plate in her lap in order to eat her meals. Findings include: R18's annual Minimum Data Set (MDS) dated 9/26/15, identified R18 had moderate cognitive impairment, and required supervision and setup from staff for eating. During observation of the lunch meal on 11/30/15, at 12:13 p.m. R18 was seated in a standard wheelchair with foot pedals at a table in the dining room with three other residents. The table was positioned approximately 12-14" away from R18, and the height of the table was even with her upper chest. R18 was served a plate of food consisting of pieces of cut-up pork chop, peas, and white rice, and placed the plate of food on her lap. R18 consumed the food using her fingers on her left hand, despite having a regular fork on her plate. At 12:30 p.m. dietary aide (DA)-A served R18 a small dish of peaches and walked away. R18 reached up to the table and picked up the small dish of peaches, and placed it in between her legs on her lap. R18 ate the peaches from her dish in her lap using her fingers. R18 finished her meal at 12:38 p.m. and left the table. During observation of the supper meal on 11/30/15, at 5:41 p.m. R18 was again seated at the same table in a standard wheelchair with foot pedals. R18 was served a plate of food consisting of a hamburger with bun, and carrot slices. R18 reached and picked up the plate from the table, still positioned even with her upper chest, and placed the plate of food on her lap.	F 246	choosing to place plate on lap. She states that she does not want further interventions put in place as this is what is comfortable for her. She stated that she has no problems reaching the table or with the table height. This is just something she chooses to do at times. Dietary spoke with resident about smaller table, resident refused. Offered resident with feeding, resident refused, states “has no problems feeding self”. Order for occupational therapy requested on 12/22/15 for evaluation with eating/feeding self. All residents will be observed for changes in dining room by nursing & dietary quarterly and as needed. If any changes are noted they will be brought to the attention of charge nurse / Dietary Manager and then brought to IDT for discussion. Resident will be interviewed and recommendations / interventions will be put in place per resident satisfaction. Occupational therapy orders will be requested for recommendations and resident teaching to maximize resident’s independence with eating. Therapy recommendations will be discussed at IDT & with resident. After recommendations have been reviewed, care plan will be reviewed and updated as appropriate per IDT and/or resident. Education on the above system process was provided to all Dietary & Nursing staff and was completed by December 21, 2015.	

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R18 began to eat the meal using her fingers with her left hand. At 5:45 p.m. R18 reached and placed the plate of food back on the table, only consuming a few bites of the diced carrots. At 5:53 p.m. R18 back herself away from the table using only her left hand, and left the dining room.

During observation of the lunch meal on 12/1/15, at 12:17 p.m. R18 was again seated at the same table in a standard wheelchair with foot pedals. R18 was served a plate of food consisting of sliced ham, au gratin potatoes, kernel corn, and a piece of buttered bread. Nursing assistant (NA)-A buttered R18's corn for her, and cut up her ham slice using the regular fork and knife provided to R18, and placed the silverware back on R18's plate. R18 picked up the regular spoon and used her left hand and took a bite of the potatoes. At 12:22 p.m. R18 picked up the piece of buttered bread using her left hand, took a bite and placed it in her lap, continuing to tear off small pieces of the bread using her fingers. At 12:28 p.m. R18 attempted to cut up a piece of pineapple upside-down cake in a small dish on the table using a regular fork, but was unable to. R18 set the fork down, and began to eat the cake using her fingers until 12:33 p.m. when she finished her meal, and left the table.

During interview on 12/2/15, at 12:12 p.m. NA-B stated staff try to give R18 a regular fork to use, but she will drop it and eat with her fingers instead. NA-B stated R18 only had use of her left hand, and will often put the food on her lap because it is, "More comfortable." NA-B stated she was not aware if adaptive silverware or a lower table had been trialed for R18 to promote better eating ability for R18.

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During interview on 12/2/15, at 12:19 p.m. NA-A stated R18 had no use of her right hand, and often eats with her fingers. NA-A stated R18 placed the plate of food on her lap to eat because she, "Feels it's easier to get at." NA-A stated she was unaware if any adaptive silverware or a lower table setting had ever been tried to help R18 feed herself.

R18's care plan dated 10/14/15, identified R18 had potential for an alteration in nutrition, and directed staff to, "Assist to open up packets and cut up food," and, "Praise independence in eating." The care plan did not identify any preference or indication R18 consumed her meals by putting her plate on her lap, or any past attempts or preferences for using adaptive silverware.

R18's most recent Nutritional Collection Tool (assessment) dated 9/21/15, identified R18 had not sustained any weight loss, but will leave, "25% or more of foods uneaten." R18 used no adaptive equipment. The assessment did not identify how much assistance with eating R18 required, or any past attempts to provide adaptive silverware or a lower eating surface to promote independence with eating.

During interview on 12/2/15, at 12:32 p.m. licensed practical nurse (LPN)-A stated R18 placed her plate of food on her lap because she, "Can't get close enough to the table." LPN-A stated she had never seen a lower table or adaptive silverware attempted to be used to help R18 with her eating and, "That's just the way she [R18] chooses to eat."

When interviewed on 12/2/15, at 12:36 p.m.

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registered nurse (RN)-B stated she had, "Noticed the same thing [R18 eating with a plate in her lap]," and stated R18 had been doing that, "For quite a long time." RN-B stated R18 had significant weakness on her right side, and it was easier for R18 to get at the food by having it closer on her lap. RN-B was unaware if adaptive silverware had ever been attempted to help R18 with her eating ability, nor was she aware if a smaller/ lower table had been tried R18.

On 12/2/15, at 12:44 p.m. physical therapist (PT)-A and occupational therapist (OT)-A were interviewed and stated R18 had never been referred or screened by therapy for concerns with eating to their knowledge, but OT-A stated therapy services could assist in assessing R18's eating ability to make eating for the resident easier.

During interview on 12/2/15, at 1:25 p.m. RN-A stated she had observed R18 use her fingers to eat before, but felt it was what R18 chose to do. RN-A stated the certified dietary manager (CDM) would have assessed R18's ability to eat, however, RN-A could not find a specific assessment which indicated any adaptations were attempted for R18.

During interview on 12/2/15, at 2:46 p.m. CDM stated she had observed R18 using her fingers to eat and had been told by staff also. CDM was unaware of any past attempts to use adaptive silverware or a lower table setting to help R18 eat easier, and stated all staff should participate in the recognition and evaluation of R18 and her eating ability.

A facility policy on adaptive equipment and

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F 246	Continued From page 13 resident needs was requested, but none was provided.	F 246		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure coordination of care and services with hospice for 1 of 1 residents (R12) reviewed for hospice care and treatments. In addition, the facility failed to ensure 1 of 1 residents (R11) reviewed for dementia care was interacted with in a manner to reduce distress and anxiety. Findings include: R12's quarterly Minimum Data Set (MDS) dated 8/29/15, identified R12 had severe cognitive impairment, required extensive assistance with activities of daily living (ADLs), had several current pressure ulcers, and received non-surgical dressings for treatment of the pressure ulcers. R12's current signed physician orders dated 10/12/15, identified an order for treatment of a stage IV pressure ulcer (full loss of skin, reaching	F 309	F 309-D The day shift charge nurse notice supplies were low, will ensure coordination of care and services with hospice for all residents that receive hospice care. Facility called hospice RN and informed them that supplies were needed. Hospice instructed the facility that they were ordering the supplies, in the interim the staff were instructed to use sterile water and dress per MD order. The facility will ensure coordination of care and services with hospice for all residents that receive hospice care by speaking with the hospice nursing staff at every visit and reviewing the supplies that are needed are available to the staff. Hospice will bring supplies out weekly with weekly visits. DON and ADON will also visit with hospice staff to ensure that supplies are available. Education of staff	12/21/15

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F 309	Continued From page 14 into muscle and tendon) which read, "LEFT BUTTOCKS DRESSING CHANGE: DAKIN SOLUTION [a solution used as an antiseptic and to decrease irritation of a wound] 25% [percent]. USE BLUNTED SYRINGE. FILL WITH 30 MLS [milliliters] AND FLUSH WOUND ..." During observation of the pressure ulcer dressing change on 12/2/15, at 7:18 a.m. licensed practical nurse (LPN)-A filled a 30 mls syringe with sterile water, not Dakin's solution per the physician orders, and flushed R12's stage IV pressure ulcer with the sterile water before applying a new dressing. LPN-A stated R12's hospice agency had not provided any of the ordered Dakin's solution yet so she was using sterile water. When interviewed on 12/2/15, at 8:04 a.m. LPN-A stated hospice was supplying all of the needed supplies for R12's dressing change, and the facility staff should have alerted hospice to the need of R12's Dakin's Solution when noted it was running low, but, they did not notify them, and the facility was out of Dakin solution and waiting for hospice to bring more to the facility. During interview on 12/2/15, at 8:41 a.m. registered nurse (RN)-B stated she contacted the hospice nurse yesterday afternoon to inform them of the need of R12's Dakin's Solution. R12's supplies hadn't been ordered, "In a timely manner," and the nurses doing the dressing changes should be monitoring the supplies to ensure they don't run out of necessary supplies and treatment equipment. During interview on 12/2/15, at 8:45 a.m. RN-A stated hospice was supplying the dressing change supplies for R12's pressure ulcer, and the	F 309	will be completed by 12/21/15 with regards to coordination of supplies of notifying hospice timely with regards to low supplies. Quarterly QA meetings will review the process and monitor compliance of staff. DON/MDS 12/21/15	

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F 309	Continued From page 15 hospice staff come to the facility twice a week and ask if the facility needed any supplies. RN-B stated the facility staff should have contacted hospice if they were running low on a supply, however, RN-A stated she felt it was hospice' responsibility to make sure R12's supplies were adequately stocked. When interviewed on 12/2/15, at 9:19 a.m. hospice nurse (HN)-A stated the facility should be monitoring their supplies and letting hospice know if more are needed. During interview on 12/2/15, at 9:42 a.m. the director of nursing (DON) stated hospice should be monitoring the supplies for R12 and bringing more when needed as it was, "Part of their responsibility." A facility policy on coordination of care was requested, but none was provided. R11's quarterly MDS dated 9/17/15, identified R11 had dementia with both long and short term memory impairment and disorganized thinking. R11's Cognitive Loss / Dementia Care Area Assessment (CAA) dated 3/23/15, identified R11 was disorientated and confused, and staff attempt to, "Redirect the resident, provide support, and cue and prompt to assist with behavior symptoms." R11's care plan dated 6/25/15, identified R11 had ineffective coping and agitation, and listed a goal of, "Reduced incidents of agitated behavior." The care plan identified interventions for R11 which included, "Keep scheduled routine & [and]	F 309		

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F 309	Continued From page 16	F 309		

predictable," and, "Redirect attention and provide support as needed." The care plan had no specific, individualized approach's for staff to utilize for R11's agitation.

During observation on 12/3/15, at 10:26 a.m., R11 exited the facility out the side door closest to the nurses station, and staff were alerted by the alarm sounding. Social worker (SW)-A, RN-E, and RN-G were present as R11 was escorted back into the facility. R11 was heard stating, "I want to go home." RN-G wheeled R11 in her wheelchair to the television room at the far end of the facility common area and walked away.

During interview on 12/3/15, at 10:26 a.m. R11 stated he was headed home and stated, "I was O.K. until someone came and grabbed me and brought me back."

Following his attempt to exit the facility, R11 was observed from 10:26 a.m., until 10:40 a.m., sitting in his wheel chair in front of the television with no staff interaction. At 10:40 a.m., R11 wheeled himself to the desk at the nurses station and began asking who the boss was, and, "How am I going to get out of here." At that time NA-F attempted to re-direct R11.

When interviewed on 12/3/15, at 1:45 p.m. RN-G stated she knew R11 was, "Confused," and had dementia. RN-G stated a housekeeper approached her this morning and told her R11 had, "Gotten out the door." RN-G went outside and R11 told her he wanted to go home. RN-G stated she wheeled him back inside and told the charge nurse R11 had been outside. RN-G stated she was unaware what interventions to do to help R11 relax, and stated she did not offer

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F 309	Continued From page 17 R11 any toileting, question if R11 had pain, or any other intervention to reduce R11's anxiety and frustration about not being able to return home because she felt he seemed, "Just fine." During interview on 12/3/15, at 2:03 p.m. RN-A stated R11 had gone outside before because he, "Usually wants to go home." R11 was typically easily re-directed, but some episodes were not, so staff would visit with him and, "See what he wants." RN-A stated staff had sometimes offered R11 to call his son which, "Has helped in the past." RN-A stated an intervention the facility used for anyone with dementia is to offer calling the family for them when having increased distress or anxiety. RN-A was not sure what the intervention on R11's care plan which directed, "Redirect attention and provide support as needed," meant and stated she would check with social services. At 2:38 p.m. RN-A stated she checked with social services and the intervention meant to re-direct R11 to a safe environment if he was demonstrating behaviors like crying, or he was physically agitated adding it was a, "Pretty broad term." When interviewed on 12/3/15, at 2:43 p.m. nursing assistant (NA)-D stated R11 had attempted to leave the facility before saying he wanted to go home. NA-D stated when R11 had these episodes she would just sit and talk to him and try to re-direct him to other topics instead of going home. NA-D stated it, "Takes a bit," of talking to calm R11 down though.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and	F 311		12/18/15

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F 311	Continued From page 18 services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to promote independence with eating for 1 of 2 residents (R38) reviewed for activities of daily living. Findings include: R38's quarterly minimum data set (MDS) dated 8/28/15 indicated the resident had severe cognitive impairment, required staff oversight with meals, staff encouragement or cueing with eating, and received a mechanically altered diet. R38's care plan dated 9/4/15, identified the resident at risk for alteration in nutrition due to the need for a mechanically altered diet with ground meats and thickened liquids. R35's care planed goal was to eat greater than 65% of meals, and directed staff to observe for any changes in the residents ability to feed herself and report changes to the residents charge nurse. During observation on 11/30/15, at 12:22 p.m. R38 was sitting at a table in the dining room with 4 other residents. R38 had ground meat, rice, and peas on her plate, and no staff was present at the table with R38. R38 sat at the table with her eyes closed until 12:57 p.m. at which time staff escorted R38 from the dining room to her room without prompting or cueing R38 to eat her meal. R38 did not eat any of her meal.	F 311	F 311 Corrective action for resident 38, family was made aware of survey findings by DON on 12/4/2015, family wrote a letter to MDH with regards to deficiency and family and resident were in agreement to continue with current plan of care due to resident not wanting to be fed. A plate guard will be added to assist in resident being able to continue to feed self. Completed on 12/18/15 by Dietary Manager. The facility; nursing, activities, dietary, and therapy, will monitor in the dining and complete quarterly assessments to assure that all residents have the appropriate interventions in place to maintain or improve his or her ability to promote independence with eating. IDT will look at each resident weekly to discuss any changes in resident□s condition that would change how the ADL□s have improved or declined. All Nursing staff, licensed and non-licensed will be educated on changes noted at meals, and to immediately inform charge nurse. DON/ADON. Completed 12/18/15. Quarterly QAPI will look at trends in weight loss, to determine further actions in ADL□s.	

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F 311	Continued From page 19	F 311		

During observation on 12/1/15, at 12:14 p.m., R38 was in the dining room and was served ground ham, pureed potatoes and corn, and pureed fruit. R38 dined at the table unassisted by staff, and only ate her pureed fruit during the meal. No staff prompted or cued R38 to eat her meal.

During observation on 12/1/15, at 5:45 p.m., R38 ate a sandwich and pureed fruit independently. R38 did not eat any of her soup, and no staff were observed prompting or cueing the resident.

On 12/2/15, at 7:22 a.m. R38 was observed sitting in the dining room for the morning meal. R38 took three bites of her fruit and then sat holding a napkin over her face. R38 sat at the table with no assistance, prompting, or cueing from staff. At 7:47 a.m. staff assisted R38 back to her room without asking the resident if she wanted anything further to eat, nor did they offer the resident any assistance. R38 left a banana and french toast sitting on her plate un-eaten.

R38 was observed on 12/02/2015, at 12:36 p.m. in the dining room with beef stew, a biscuit, and chocolate pudding in front of her on the table. R35 ate approximately 75 percent of her biscuit, and all of her pudding, however, the beef stew remained uneaten. R38 left the dining room with no cueing or prompting from staff.

A review of R38's meal intakes dated 11/1/15, to 12/2/15, indicated she ate "fair" to "poor" on 46 separate occasions. "Fair" defined as 50-75 percent, and "poor" defined as eating less than 50 percent. However, there was no indication the charge nurse was notified R38 was eating less than 65 percent of her meal, nor was there any

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further assessment to determine if any further interventions needed to be implemented to promote independence with eating.

During interview on 12/2/15, at 12:46 p.m. registered nurse (RN)-B stated R38's eating habits were generally "fair to poor." RN- B stated R38's intakes have decreased over the past month or two, and R38 usually did not required staff assistance with eating except for setting up her meal. RN-B stated R38 was recently referred to occupational therapy, however, the referral was due to cognition and not related to her ability to feed herself.

During interview on 12/2/15, at 12:57 p.m. the dietary manager (DM) stated R38's eating had been stable. She stated monitoring was done by the dietary staff.

On 12/2/15, at 12:58 p.m. cook (C-A) was documenting R38's intake for the lunch meal. C-A documented R38 had eaten 75 percent of the noon meal. However, RN-B was asked to verify R38's intake, and RN-B stated the intake was actually considered only about 25 percent.

During interview on 12/3/15,at 9:39 a.m. R38 stated she had, "Trouble getting meat to stay on her fork," and the "fruit is easier to eat." R38 stated she does not receive help with meals, but has trouble keeping food on the utensils.

During interview on 12/3/15, at 9:39 a.m., occupational therapist (OT)- A stated, R38 had not been seen in therapy since December of 2014, and they had not assessed R38's ability to eat independently.

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F 311	Continued From page 21 During interview on 12/03/2015, at 10:05 a.m. nursing assistant (NA)- G stated, R38 usually eats "okay" but doesn't eat all of her food. NA-G stated R38 does not need any assistance. A policy regarding intake monitoring was requested but none was received.	F 311		
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 residents (R16) with complaints of poor vision had follow-up provided for an eye exam as recommended by her physician. Findings include: R16's quarterly Minimum Data Set (MDS) dated 8/6/15, identified R16 had severe cognitive impairment, wore corrective lenses, and had, "Adequate" vision which included being able to see fine print. During interview on 11/30/15, at 1:35 p.m. R16	F 313	F 313 Corrective action with R 16; an appointment has been made with local eye doctor on 12/22/15 for an exam, charge nurse ; the ADON has contacted the daughter and informed her of the appointment the family has chosen not to attend appointment. Nursing staff will be educated on reviewing MD progress notes/dictation and following with any recommendations and initially and dating all progress proving that they have been reviewed, using the same procedure as a written order.	12/18/15

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F 313	Continued From page 22 was seated in a wheelchair in her room. The room was quiet and there was no radio or television on. R16 stated her, "Eyes are getting weaker," and she was no longer able to read. R16 stated it was even difficult to watch television because of her worsening eye sight. R16 stated she thought her last eye exam was over a year ago, and she, "Should have them [eyes] checked." When interviewed on 11/30/15, at 6:39 p.m. family member (FM)-K stated R16 had complained about her worsening eye sight during visits, and FM-K was not sure when R16's last eye appointment was stated making eye appointments was something, "They [facility] take care of there." R16's progress notes dated 9/22/14, identified R16 had been, "Seen by the IN House Senior Services optometrist for a routine eye exam." The notes did not identify if the optometrist made recommendations or changes in the plan of care for R16. R16's optometry Clinical Note dated 9/22/14, identified R16 had been seen for an, "Eye Exam," and identified R16 had macular degeneration (eye disease causing vision loss). The note identified a recommendation from the physician, "Return Visit in 1 year." R16's facility Hearing/Speech/Vision assessment dated 10/29/15, identified R16 wore corrective lenses, and had, "Adequate," vision in the light. The assessment did not identify her last eye examination or future follow-up despite R16's eye exam which had been completed on 9/22/14, with a recommendation to follow up in one year.	F 313	The facility on an quarterly basis/ or with significant change, with the MDS assessments address with the residents the need for further care, from an outside provider, ie dental, eye exams, podiatry, and hearing. The IDT staff will meet weekly to discuss each resident for changes in ADL□s or function, and to make further recommendations for continued care. DON/ADON 12/18/15.	

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F 313	Continued From page 23 During interviewed on 12/3/15, at 9:10 a.m. trained medication aide (TMA)-K stated R16's eye sight was, "Not good," and she was not surprised R16 had complaints of worsening vision. TMA-K stated R16 seemed to be more confused lately and adding it was, "Maybe because of her eye sight." During interview on 12/3/15, at 9:32 a.m. registered nurse (RN)-A stated the medical records coordinator was responsible to set up all resident eye appointments. RN-A stated she was unaware of any concerns R16 had about her worsening eye sight. When interviewed on 12/3/15, at 9:43 a.m. medical records coordinator (MRC) stated R16 was not on the current listing to be seen by the In House optometrist, but should have been given the recommendations from her 9/22/14, examination. MRC stated she was unaware how R16's recommendations for a yearly eye examination had been missed, and stated R16 should have seen for a recheck in September 2015. A policy of coordination of care with outside providers was requested, but none was provided.	F 313		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		12/18/15

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F 315	Continued From page 24 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and develop interventions to promote urinary continence for 1 of 2 residents (R16) with severe cognitive impairment reviewed for urinary incontinence. Findings include: R16's quarterly Minimum Data Set (MDS) dated 8/6/15, identified R16 had severe cognitive impairment, required limited assistance with toileting, was frequently incontinent of urine, and a trial of a toileting program had not been attempted. R16's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 11/14/15, identified R16 had restricted mobility along with urinary urgency and a need for assistance in toileting which contributed to her incontinence. R16 was identified as, "Frequently incontinent of bladder," and would have care planned interventions to, "Minimize risks," of urinary incontinence. The CAA did not identify why R16 had never been trialed on a scheduled toileting program as identified by the MDS. During observation on 11/30/15, at 1:35 p.m. R16 was seated in a wheelchair in her room. R16 had a strong odor of urine present, but was not visibly	F 315	F 315 Corrective action with R16, resident was interviewed by the MDS nurse on 12/18/15, for an elimination plan, resident, denied any incontinence issues, swearing at staff, stated I will go when I want to go when staff offered a prompted toilet program resident responded I don□t care what the hell you want to do . Resident then ended any further conversation. The MDS nurse will Care plan interaction and the resident□s feelings with regards to a formal toiling plan. All nursing staff will offer toileting upon rising, before meals and after meals, at bed time, assist if noted by staff of resident taking self. Family was notified of care planning. 12/18/15. DON/ADON All residents will be assessed upon admission, at significant changes and annually, for elimination care planning. Findings will be care planned for and discussed at care conferences with resident and families. QAPI will monitor UTI in all residents for patterns and trends. DON/ADON 12/18/15.	

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F 315	Continued From page 25 soiled with urine. R16's Bowel and Bladder 3.0 assessment dated 10/29/15, identified R16 had never been trialed on a toileting program and was, "Frequently incontinent," of urine. Further, a section on the assessment titled, "RN [registered nurse] EVALUATION OF 48 HOUR BOWEL AND BLADDER ASSESSMENT," was left blank. The assessment did not identify any assessment of R16 to determine why she was incontinent, any interventions for R16 to reduce her incontinence, patterns of voiding, or potential to participate in a scheduled toileting program. R16's care plan dated 5/19/15, identified R16 had impaired elimination and was, "Frequently incontinent." The care plan identified interventions for R16 which included, "If resident is soiled or odorous, encourage her to allow assistance with toilet use/cares," and, "Respect resident's right to decline a scheduled toileting plan and her right to refuse assistance with toileting." The care plan did not identify the amount of assistance R16 required with toileting, any identified times to prompt of encourage toileting to reduce incontinence for R16, or any specifics regarding if R16 had ever been offered and refused a scheduled toileting program. During observation on 12/1/15, at 10:32 a.m. R16 was seated in her wheelchair in her room, wheeling herself into the restroom, closing the door behind her. At 10:36 a.m. R16 illuminated the call light outside the restroom for assistance, and nursing assistant (NA)-B responded. At 10:41 a.m. NA-B opened the door from R16's room and exited with a clear plastic bag in her hand which contained R16's clothing which was	F 315		

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brought to the soiled utility room down the hallway.

When interviewed on 12/1/15, at 10:42 a.m. NA-B stated R16's pants were, "Soiled," with urine because R16 would typically, "Wait until the last second," to ask for assistance with toileting. R16 was not on any scheduled toileting program, and staff would only assist her her if they saw her heading into the restroom. NA-B stated R16 voids on the toilet after sitting down on it, even if she had already been incontinent.

During interview on 12/1/15, at 11:07 a.m. registered nurse (RN)-B stated R16 tended to be incontinent of urine, and staff assisted her when they find her in the restroom. R16 was not on any scheduled or prompted toileting program, but did have continent voids after being placed on the toilet.

R16's medical record was reviewed. There was no documentation or assessment which identified R16 had refused a scheduled or prompted toileting program, nor if R16 had been provided a explanation of the risks of not participating in a scheduled or prompted toileting program despite her incontinence.

On 12/1/15, at 12:39 p.m. director of nursing (DON) and RN-A were interviewed. DON stated R16 had a, "Problem of impaired elimination," and poor cognition adding they were aware R16 was not able to make the best decisions for herself. The DON stated R16 was not on a scheduled toileting program because she had refused one in the past. R16's bed and linens were cleaned daily because of her incontinence, but staff do not prompt her to use the toilet to

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F 315	Continued From page 27 respect her right to manage her own care, despite her cognitive impairment. R16 was checked for incontinent only by staff. RN-A stated R16's responsible party had ever been provided an explanation of risks or benefits of a scheduled toileting program because she hadn't been able to reach her. During a follow up interview on 12/1/15, at 1:12 p.m. RN-A stated was unable to locate any further documentation on R16's bladder assessment to show the individualized assessment of the 48 hour toilet tracking, but again stated R16 was not on a scheduled toileting program, "Because it was her choice." A facility Bowel and Bladder Training Program policy dated 6/2012, directed staff to, "Observe and record the resident's voiding pattern to assist in establishing a training schedule," and, "Per the individualized bowel and bladder assessment, encourage the resident to go to the bathroom." Further, the policy directed staff to assist the resident to the bathroom upon awakening in the morning, before each meal, after napping, and before activities even if they are not on a scheduled toileting program.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT 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.	F 323		12/4/15

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F 323	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were re-assessed to determine whether interventions were necessary to maintain their safety, for 3 of 3 residents (R37, R16 and R12) identified, who spilled hot coffee on themselves. In addition, the facility failed to ensure 1 of 1 residents (R88) observed to drop his lit cigarette on himself was assessed for safety with smoking immediately upon admission. Findings include: R37's Order Summary Report dated 12/1/15, identified diagnoses including generalized muscle weakness, and hemiplegia and hemiparesis following cerebral infarction (stroke). R37's quarterly Minimum Data Set (MDS) dated 9/16/15, identified the resident had no cognitive impairment, required extensive assistance for most activities of daily living but was independent after set-up with eating, and had functional limitations to range of motion on one side of both her upper and lower extremities. R37's Care Area Assessment (CAA) dated 6/25/15, identified R37 had diabetic retinopathy, with visual field deficit and decreased visual acuity, and had physical limitations including weakness, limited range of motion, poor coordination, poor balance, visual impairment, and pain. R37's care plan dated 9/26/15, directed staff to observe for any changes in the residents ability to	F 323	F 323 Corrective action for residents 37, 16, and 12; our immediate corrective action was to provide first aide to the residents, MD notification, and scheduled monitoring by nursing staff until injury resolved as evidenced by documentation in POC for each resident, incident report, & MD notification. New mugs with covers were ordered and now available for residents to use to prevent/decrease the risk of burns. Order for occupational therapy to reassess safe hot beverage handling indicated residents was requested on 12/22/15. Systems approach for all residents was to purchase mugs with covers, so they are available for residents to decrease the risk of injury from coffee. Dietary Manager will monitor residents in regards to handling beverages are to be done quarterly and/or as needed. DON & Dietary Manager provided education to all CNAs on how to monitor residents on handling hot beverages safety & to inform charge nurse or Dietary Manager promptly of any concerns noted. Weekly discussion at IDT meetings will occur to address any resident concerns that have been noted and to determine interventions and plan of care as appropriate. Per IDT, resident's physician will be updated. A request for occupational therapy order will be obtained in regards to safe hot beverage handling, resident education, & recommendations. Recommendations will	

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F 323	Continued From page 29 feed herself and to report those changes to the charge nurse. R37 was to receive assistance with meal set up and receive praise for her independence in eating. The care plan did not include any directions specific to R37's safety with hot beverages. A Resident Incident/Accident Report dated 10/22/15, at 5:00 p.m. identified R37 self-reported she had spilled coffee on herself that evening. The charge nurse assessment indicated, "Resident spilled coffee on her chest and has red mark that measures 5.5 cm [centimeters] x [by] 3.5 cm." No further investigation or assessment was identified on the report. Review of R37's Progress Notes from 10/22/15, through 11/30/15, identified the following: On 10/22/15, at 7:21 p.m. registered nurse (RN)-D noted, "Alteration in skin report completed." No further information was provided. On 10/23/15, at 8:59 a.m. licensed practical nurse (LPN)-C noted, "Resident has blistered areas and also water blisters on her chest from her coffee spill yesterday. Measuring 5.5 x 3.5 cm." The note identified R37 had an appointment scheduled with the nurse practitioner on 10/23/15. On 10/23/15, at 10:00 a.m. RN-B noted, "Resident returned from appointment with [nurse practitioner (NP)-A], regarding water blisters on resident's chest. [NP-A] notes, 'partial thickness superficial burn.' New orders for bacitracin ointment to burn area TID [three times daily] for 7 [seven] days. Cool compress to area PRN [as needed] for pain/itching every 2 [two] hours x [for] 20 minutes as needed. Keep blister intact as able. Give Tylenol for pain PRN."	F 323	be discussed at IDT and with resident. After recommendations have been reviewed, care plan will be reviewed and updated as appropriate per IDT and/or resident. Per recommendations from therapy/IDT; Nursing Assistants will offer coffee mugs with lids with all hot beverages & will document via task in POC. Task will be monitored per MDS schedule and/or as needed by MDS nurse. 12/22/15 ADON	

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R37's progress notes included routine monitoring of R37's burns until they were healed on 11/15/15, however, the progress notes lacked any investigation or assessment of R37's safety after having spilled hot coffee on herself resulting in burns.

R37's Alteration In Skin Collection Tool reports from 10/22/15, through 11/15/15, included routine monitoring of burns to R37's chest area, until the area was healed. However, the reports lacked any investigation or assessment of R37's safety after having spilled hot coffee on herself to determine if any further interventions were needed.

Review of the facility's IDT (interdisciplinary team) Meeting Log notes from 10/22/15, through 11/30/15, lacked any notation of R37 having spilled hot coffee on herself to determine if any interventions were needed to prevent further spills.

During observation on 12/1/15, at 8:49 a.m. R37 was seated in her wheelchair, eating breakfast in the dining room. R37's meal was set up, with no adaptive equipment or cover to her hot coffee. As she ate her meal, she was observed with left-sided weakness, showing no movement of her upper left extremity and had a small amount of hot cereal/ oatmeal spillage from the left side of her mouth, onto her chin. All of her beverages were placed to the right side of her place setting and the resident appeared to have no difficulty reaching for or handling her cups, coffee mug, or eating utensils.

On 12/1/15, at 12:37 p.m. R37 was seated in her

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wheelchair at the dining room table, eating her lunch meal. She was observed with limited use of her left hand, but was using her left thumb and forefinger to brace her plate while she ate with her right hand. R37 demonstrated no difficulty handling her coffee mug, taking a drink, and swallowing her coffee. At 12:48 p.m., R37's meal card was observed at her place setting in the dining room. The meal card lacked any direction for staff with regards to hot beverages, cup/mug covers, or prompting/ assistance needs for eating.

During interview on 12/1/15, at 1:11 p.m. R37 stated she had to go to the doctor for burns to her chest area from spilling hot coffee on herself on 10/22/15. R37 stated she had never spilt coffee before, and she was able to hold her right arm and hand steady and she felt secure while holding a mug of hot coffee. She stated the incident of burning herself was an accident and she had just tipped the cup a bit too far toward her chest, before it got to her mouth. R37 stated the facility had not talked to her about using a cover for her hot beverages, and agreed she would have been willing to use a cover if the facility staff had requested this, however, R37 stated she didn't feel this was necessary.

During interview on 12/1/15, at 3:10 p.m. the certified dietary manager (CDM) stated the dietary staff communicated to staff the need for resident adaptive equipment or altered dining set-up needs via a communication book kept in the facility's kitchen. Upon review of the communication book, no mention was made regarding R37's coffee burn or safety precautions with hot beverages. The CDM stated each resident had a meal card which was also a

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reference for any residents who may have required adaptations. The CDM stated she was not aware if R37 required any specialized set-up for her meals or beverages, nor was she aware of any residents who had been burned with hot coffee since she started working at the facility on 10/2015.

R16's Order Summary Report dated 12/3/15, identified diagnoses including chronic pain and macular degeneration.

R16's quarterly MDS dated 8/6/15, identified the resident had severe cognitive impairment, required limited assistance for most activities of daily living, and required only supervision and set up with eating.

R16's CAA dated 11/14/15, indicated R16 had decreased visual acuity and visual field deficit, and had physical limitations including weakness, limited range of motion, poor coordination, poor balance, visual impairment, and pain.

Review of R16's Progress Notes from 7/8/15, through 11/30/15, identified the following:

On 7/8/15 at 12:30 p.m. LPN-B noted, "At 11:30 [a.m.] resident noted to have spilled a hot cup of coffee on her chest. Resident assisted into her room and assisted to change her clothes. Noted resident to have some slight redness on her left breast. Resident denies pain to this area. At 12 [12:00] p.m. resident was given a cup of coffee (this coffee was cooled) and was noted to have spilled this coffee on her abdomen. No redness to this area noted. Resident also noted to have increased involuntary jerkiness to upper extremities." The progress note included, "Will

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monitor chest for any further redness," and R16's physician was notified.
On 7/11/15, at 1:45 p.m. RN-E noted, "[R16] was sitting in the lobby by the TV and spilled cool coffee on herself. She was taken to her room and her clothes were changed. She did not have any redness present on her skin from the coffee on exam. The coffee was cool from sitting."
On 8/3/15, at 2:02 p.m. RN-C noted R16, "Continues to be sleepy during the day," identifying she was falling asleep at the dining room table.
The progress notes lacked any investigation or assessment of R16's safety after spilling hot coffee on herself to determine if any further interventions were needed.

Review of R16's medical record lacked any Resident Incident/Accident Reports or Alteration in Skin Collection Tool reports which addressed R16 having spilled hot coffee on herself and/or assessed her safety with hot beverages.

Review of the facility's IDT Meeting Log notes from 7/2/15, through 11/30/15, included on 7/9/15, the meeting minutes noted, "Review CP [care plan] to address coffee spills [and] visit [with] resident regarding her spills." Review of R16's medical record lacked any follow up noted on R16's care plan, nor did the notes indicate any assessment or interventions put into place to prevent further spills.

R16's care plan dated 11/12/15, directed staff to observe for any changes in her ability to feed herself and to report those changes to the charge nurse. R16 was to receive assistance with meal set up and receive praise for her independence in eating. The care plan did not include any

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directions specific to R16's safety with hot beverages.

During interview on 12/3/15, at 10:24 a.m. LPN-A stated she was aware of R16's history of spilling coffee on herself, and stated she tries to serve R16's coffee to her luke warm.

During interview on 12/3/15, at 10:27 a.m. nursing assistant (NA)-E stated she was aware R16 had spilled coffee a couple of times in the past, and she typically added cool water, poured only half a cup, or let R16's coffee cool before serving it to her. NA-E stated, "But half the time she goes up [to the coffee machines in the dining room] to get coffee herself."

During observation on 12/3/15, at 12:59 p.m. R16 was observed seated in her wheelchair at the dining room table with her head lying down on the table and her eyes closed. R16's hand was draped over her coffee cup. R16 then became alert, took a drink of coffee from her cup, and then self-propelled from the dining room table.

R12's Order Summary Report dated 12/3/15, identified diagnoses including restlessness, dizziness, disorientation, quadriplegia, traumatic brain injury, seizure-like activity, and dementia.

R12's quarterly MDS dated 8/29/15, identified the resident had severe cognitive impairment, required extensive assistance for most activities of daily living, and required supervision with eating.

R12's CAA dated 11/21/15, identified R12's physical limitations included weakness, limited range of motion, poor coordination, poor balance,

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visual impairment, and pain.

A Resident Incident/Accident Report on 9/16/15, at 7:45 a.m. indicated, "Resident [R12]spilled hot coffee on his Rt [right] thigh. Clothes immediately lifted off resident's leg and changed. [No] redness noted." The report indicated R12 was sitting at the breakfast table in the dining room at the time of this incident. The charge nurse assessment noted, "Cup of coffee was sitting to [sic] close to the edge of the table and resident bumped it when attempting to reposition self at the table." No further investigation or assessment was identified on the report to determine if any interventions were needed.

R12's Alteration In Skin Collection Tool report dated 9/16/15, noted, "Resident was sitting at the dining room table at breakfast time and spilled hot coffee on his right thigh. Clothes immediately lifted off resident's leg and changed. No redness noted... Monitor for blistering and F/U [follow up] with MD [medical doctor] as needed."

R12's care plan dated 11/19/15, directed staff to observe for any changes in his ability to feed himself and report changes to the charge nurse. R12 was to be provided with adaptive silverware and receive praise for his independence in eating. The care plan did not include any directions specific to R12's safety with hot beverages.

Review of R12's progress notes from 9/16/15, through 11/30/15, identified the following:

On 9/16/15, at 8:15 a.m. LPN-B noted, "Resident spilled hot coffee [on] his right thigh, while sitting at the table for breakfast. Clothes immediately lifted off resident's leg and changed. No redness

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noted." No further information was provided. The progress notes included routine monitoring of R12's right thigh for blistering, though no blisters appeared. The progress notes lacked any assessment of R12's safety after having spilled hot coffee on himself to determine if any interventions were needed.

Review of the facility's IDT Meeting Log notes from 9/16/15, through 11/30/15, lacked any notation of R12 having spilled hot coffee on himself.

During interview on 12/1/15, at 11:13 a.m. the director of nursing (DON) stated the facility did not have any incident reports related to the residents coffee burns as the facility shreds them after three months. DON stated any trending of incidents/ accidents for an individual resident was done through the facility's interdisciplinary (IDT) meetings, and any follow-up or interventions developed from an incident was documented in the individual resident's care plan, with each care plan update being dated to correspond with the timeframe during which the incident had occurred.

During interview on 12/1/15, at 3:11 p.m. NA-C stated she assisted with passing out snacks and coffee to residents on a routine basis, however, coffee machines were always available in the dining room for residents to obtain coffee at any time. NA-C was not aware any residents in the facility had been burned from coffee, and there were no special interventions she was aware of for any specific residents when serving them hot beverages.

During interview on 12/1/15, at 3:20 p.m. NA-D

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stated she was not aware any residents had been burned by coffee, and coffee was available for all residents in the dining room at all times.

During interview on 12/1/15, at 3:12 p.m. cook (C-A) stated he was not aware any residents had been burned from coffee, nor was he aware of any special monitoring or interventions in place for any residents with hot beverages.

During interview on 12/1/15, at 3:13 p.m. C-B stated the facility had switched from using Styrofoam cups for hot beverages to using plastic mugs during snack time a few months prior, because a R16 had spilled her hot coffee. However, she was not aware of any other residents who had spilled coffee or required supervision or interventions when drinking hot beverages.

During interview on 12/1/15, at 5:15 p.m. the DON stated the facility had completed no additional follow-up after R37, R12, and R16 spilled hot coffee on themselves. She stated if there was nothing in the resident assessments, care plans, progress notes, or IDT meeting minutes, then there was no further assessments or follow up completed.

The facility's Incident/Accident Reporting policy dated 9/15, defined incidents as any event or occurrence that was out of the ordinary. The policy directed a systematic process was to be in place for investigating such incidents. The procedure for each incident included the following: An incident report was to be completed within 24 hours of the incident. The report was then to be forwarded to the director of nursing (DON), social services, the facility administrator

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and the resident assessment coordinator for review and investigation. Upon completion of the review and investigation, the report was to be filed and tracked for internal purposes. The procedure also directed nursing to "provide prompt follow up action" and to revise the resident's care plan as needed.

R88 was admitted to the facility on 11/30/15. The admission history and physical notes dated 11/30/15, indicated R88 was, "Diabetic with peripheral neuropathy- peripheral neuropathy in legs that has worsened and now involves his hands. Markedly decreased sensation in feet and some decreased sensation symmetrically in distal upper extremities."

A smoking assessment for R88 was completed on 12/1/15, which indicated R88 had difficulty using his right hand due to broken ribs and neuropathy. The assessment further indicated, "The resident must be able to perform all of the physical tasks assessed to be permitted to smoke in the designated smoking areas." The assessment task that indicated whether R88 could hold his cigarette in each hand without dropping it was left blank as was the section indicating R88 had the ability to dispose of ashes and butts appropriately. The assessment was not signed by a licensed nurse.

During observation on 12/1/15 at 1:20 p.m., R88 was observed sitting outside, across the parking lot from the facility in a wheel chair. R88 held a cigarette in his right hand. While talking, R88 dropped his cigarette out of his hand and it landed between his knees leaving ashes on his pant legs from his knees to approximately mid thigh. No burns were observed in R88's pants.

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R88 made multiple attempts to retrieve the cigarette from between his legs and was able to pick it up without assistance. R88 was then observed propelling himself back to the facility. R88 reached a dip in the side walk about half way to the facility door and was unable to maneuver himself up and over the hump on the far side of the dip. R88 had to wheel himself into the driveway of the facility to propel himself back into the building.

During interview on 12/1/15, at 1:30 p.m., R88 stated he was just admitted to the facility yesterday, and had been outside smoking a "few times" last night and this morning. R88 stated someone from the facility came outside with him and watched him smoke this morning. R88 stated, "I signed the paper stating if I burnt myself up, they [the facility] aren't responsible."

During interview on 12/1/15, at 3:06 p.m., TMA- A stated if a resident requests a cigarette, she would need to ask the charge nurse for approval. She stated she had given R88 cigarettes since he was admitted to the facility.

During interview on 12/1/15, at 3:06 p.m. assistant director of nursing (ADON) stated she usually completes the smoking assessments for residents, and if a residents wishes to smoke she will go outside with them, observe them smoking, and ask them some questions. She stated if there is a "check mark" on the smoking assessment that meant the resident did OK with the observation of smoking, however, if there was not a check mark, she would make a note on the smoking assessment of the issues that were observed regarding resident safety and smoking. The ADON stated R88's assessment was "not

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quite done."

During interview on 12/1/15, at 3:08 p.m. registered nurse (RN)- C stated if a resident was admitted to the facility and they wish to smoke the facility does a smoking assessment. She stated R88's smoking assessment was completed by the ADON, however, it was not complete. RN-C stated when R88 came to the facility he had cigarettes and a lighter with him and staff labeled the items with his name and locked them in the medication cart. RN-C stated she gave staff approval to give R88 his cigarettes and lighter prior to being assessed, and stated R88 knew he had to ask staff and leave the facility grounds to smoke. RN-C stated the ADON completes the smoking assessment, so if a resident is admitted on the weekend or evening, the ADON will complete the assessment when she is working.

During interview on 12/1/15, at 3:24 p.m. R88 stated he was admitted to the facility after several falls at home, and he was unable to get back up without help. R88 stated about six months prior he had been hospitalized and woke up with no feeling in his hands. He stated the loss of feeling in his hands was related to neuropathy and affected both hands and he is unable to write anymore and uses adaptive silverware at home. R88 stated he had not dropped cigarettes while smoking prior to admission to the facility, and he felt he was able to get across the street from the facility to smoke although there were some dips in the sidewalk but stated, "I can turn backwards and push if I have to."

During a follow up interview on 12/1/15, at 3:58 p.m. stated she does the resident smoking assessments, and if a resident was deemed

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unsafe to smoke, they were encouraged to quit smoking and provided education regarding the risks of smoking. ADON stated the facility cant stop residents from smoking, however, the facility will not assist the resident with smoking materials. ADON stated they had never had anyone who was assessed as unsafe to smoke independently. ADON stated R88 used his left hand to smoke, and she felt he was safe to smoke interdependently, however, she did state she had to assist R88 back to the facility as he was unable to get back independently after smoking.

During interview on 12/1/15, at 4:04 p.m. DON stated if a resident admits on the weekend that wants to smoke the nurses will evaluate the resident for safety and get orders for smoking cessation products if necessary, and explain the smoking policy to the resident. The DON stated the facility does not assist residents to smoke, however, they do hold and provide the resident their smoking materials.

During a follow up interview on 12/1/15, at 4:47 a.m. ADON stated the facility determined they would be assisting R88 outside when he wanted to smoke and staff would supervise him until he was finished smoking to ensure he was safe.

A facility policy labeled Oak Terrace Health Care Center of Gaylord, L.L.C. Smoking Assessments dated October of 2015 was reviewed. The policy indicated who desire to smoke and refuse to abide by the fact that our facility is a smoke free environment will be appropriately assessed and monitored for safe technique while at Oak Terrace Health Care Center of Gaylord, L.L.C.

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F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure all necessary supplies were available for specialized care needs for 1 of 1 resident (R64) with a tracheostomy, whose trach was dislodged and required replacement. Findings include: R64's admission Minimum Data Set (MDS) dated 10/30/15, identified R64's cognition was moderately impaired, required extensive assistance for most activities of daily living, and required special treatments/ procedures, including suctioning and tracheostomy (trach) care. R64's Medication Review Report (current physician orders) signed 11/3/15, identified diagnoses including tracheostomy placement, disease of the vocal cords and anxiety.	F 328	F328 Corrective action for resident 64; our immediate corrective action was RN charge nurse assessment to determine respiratory status. On call doctor was promptly notified post assessment for further instruction. Resident□s condition was continuously monitored until the ambulance crew arrived to transport resident to the Hospital per MD order. The DON/MDS will ensure proper equipment is readily available prior to admission of any patient with a trach. The supplies will be located in the resident□s room where they will be readily available for emergency use. 12/18/15 DON/ADON	12/18/15

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Treatment orders included: Change trach as needed to clean or prevent plugs, change trach ties weekly, leaving one finger width between skin and ties, "As she likes to pull on the trach," tracheostomy suction three times daily and as needed to clear the airway, change suction tubing daily, tracheostomy changed monthly, and provide trach care every shift.

During observation in the main dining room on 11/30/15, at 6:16 p.m. the facility's nursing staff were alerted that R64's trach had dislodged. Registered nurse (RN)-C promptly responded, approaching R64 and assisting her back to her room. R64 was observed holding both the inner and outer cannulas in her hands, with her stoma site exposed. Once in her room, RN-C was observed searching through R64's night stand drawers, closet, and bathroom supply bins. RN-C alerted licensed practical nurse (LPN)-B, who also entered R64's room and searched through the night stand drawers, closet, and bathroom areas. RN-C left and re-entered the room multiple times, commenting that she needed to look for supplies in the medication room and in the lower level of the facility for R64's trach. LPN-B stated R64 had just recently moved into this room and thought perhaps the trach supplies were put in a different place than was typical. After approximately five minutes, RN-C re-entered R64's room and stated she was unable to locate the necessary supplies to replace the trach. RN-C said, "We've gotta send her in." LPN-B stated they were sending R64 to the emergency room for trach placement because the necessary supplies were not on hand at the facility. LPN-B promptly placed a pulse oximeter on R64's finger to monitor her oxygen levels, which had remained at 98-99% on

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room air. At 6:30 p.m., RN-C notified R64's physician of the residents trach dislodging, and received an order for R64 to be sent via ambulance to the hospital. At 6:40 p.m., paramedics arrived and R64 was transported to Glencoe Regional Health.

During interview on 11/30/15, at 7:29 p.m. RN-C stated the facility normally had one replacement trach in the room, however, they were unable to locate a replacement after searching in all of the drawers in R64's room, the charting room, and in the lower level of the facility. RN-C stated since they were unable to find the replacement, R64 needed to be sent to the ER. RN-C stated the facility receptionist did the ordering for supplies when nursing let her know they were in need of resident supplies. RN-C stated that to her knowledge, R64's trach was placed within the past year and this was the first incident of the residents trach becoming dislodged since her admission to the facility.

During interview on 12/1/15, at 11:13 a.m. director of nursing (DON) stated staff should be following the physician's orders if R64's trach became dislodged. She stated the facility did have emergency supplies on hand, but did not have every potential size or specification that may have been necessary. DON stated upon admission of a resident with a trach, the facility should ensure all supplies that may have been necessary for the care of that specific resident's trach be readily available. At 5:08 p.m., the DON stated the supplies to replace R64's trach were located in the facility and RN-C had been re-educated on where the supplies were located.

The facility's Tracheostomy Care policy dated

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F 328	Continued From page 45 11/1/15, directed, "If decannulation occurs, notify the physician immediately for further instruction." The policy detailed supplies necessary for tracheostomy cleaning, but did not address supplies necessary for emergent replacement of the inner and outer cannula. The facility's Tracheostomy Care Standing Orders policy dated 12/1/13, detailed equipment and supplies necessary for care of a tracheostomy site. The listed supplies included an extra trach for emergencies.	F 328		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental recommendations were completed for 1 of 3 for residents (R35) who requested dental services related to dentures. Findings include: R35's quarterly Minimum Data Set (MDS) dated	F 412	F 412 Corrective action for resident 35; our immediate corrective action was the MDS nurse interview with resident if he wanted to pursue dentures, the resident wishes to pursue dentures and follow up with the Guardian and left a message. 12/18/15. As of 12/21/2015 have not heard back from the guardian, the MDS nurse will call	12/18/15

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F 412	Continued From page 46 10/21/15, indicated the resident had no cognitive impairment, required supervision with activities of daily living, and was able to eat independently after set up. R35's dental care area assessment (CAA) dated 7/21/15, indicated a dental appointment was to be set up for next in house dentist visit. R35's care plan dated 10/29/15, identified risk for alteration in nutrition due to mechanically altered diet and indicated R35 was missing the top denture. Review of In House dental progress note dated 9/23/15, indicated R35 was seen for lost dentures and was evaluated for a new upper denture. The note further indicated R35 was interested in a new upper denture and, "Seemed irritated that it will take so many steps and cannot be done faster," however, there was no evidence the facility followed up with R88 or his guardian to determine if R88 wanted to proceed. During interview on 11/31/5, at 6:38 p.m. R35 stated he lost his upper denture prior to admission to the facility. He stated several people at the facility had asked him if he was interested in having new dentures, and he told them he was, however, "That's as far as it went." During observation on 12/1/15, at 6:12 p.m. R35 was eating his dinner meal independently. R35 ate 100% his soup, and most of a sandwich which had ground meat in, however, the resident picked off the crust and stated, "I have a little trouble chewing the crust." During meal observation on 12/2/15, at 12:16	F 412	the guardian on 12/22/15 to follow up. Nursing staff will be educated on reviewing MD progress notes/dictation and following with any recommendations and initial and dating all progress notes/dictation proving that they have been reviewed, using the same procedure as a written order. The care plan team will on a quarterly basis or with significant change with the MDS assessments address with the residents the need for further care, from an outside provider, i.e.; dental, eye exams, podiatry, and hearing. The IDT staff will meet weekly to discuss each resident for changes in ADLs or functional status, and to make further recommendations for continued care. DON/ADON 12/18/15.	

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p.m. R35 received beef stew, a biscuit, and chocolate pudding. R35 ate the chocolate pudding, ate the beef stew but left the large pieces of vegetables in the bowl, and left the biscuit untouched on his plate.

During interview on 12/3/15, at 10:49 a.m. registered nurse (RN)-E stated R35 was able to feed himself. RN-E was not aware R35 was interested in new dentures and stated the medical records department was responsible for following up on referrals for dental services.

During interview on 12/13/15, at 10:53 a.m. medical support staff (SS)-A stated she made appointments for dental services in the facility, however, she was unaware R35 required a dental appointment, and there was no follow up scheduled for dental care.

During interview on 12/3/15, at 12:51 p.m. RN- A stated she attended a care conference with R35's guardian and stated the guardian was aware R35 had no upper teeth and did not express any concerns.

During interview on 12/3/15, at 12:58 p.m. the director of nursing stated if the facility was given information for a follow up on an appointment, the family would be contacted. DON stated she was not aware either R35 or his guardian expressed to the facility he wanted new dentures, and that would be the dentists responsibility to follow up with R35's family.

Although R35's care plan indicated he was edentulous and assessments indicated he expressed a desire to see the dentist, and even though the dentist progress note indicated R35

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F 412	Continued From page 48 expressed interest in new dentures, the facility made no attempts to assist R35 with follow up regarding his dental needs. A policy regarding dental services was requested but not provided.	F 412		
F 441 SS=F	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. (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.	F 441		12/21/15

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F 441	Continued From page 49 (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 interview and document review, the facility failed to perform tracking, trending, and analysis of resident infections . This had the potential to affect all residents, visitors, and staff in the facility. Findings include: A review of the facilities infection control logs dated October 2014, through September 2015, indicated the facility tracked infections which required treatment using antibiotics. The logs identified the resident name, dates antibiotics were started and completed, and which antibiotic was used. The logs further identified symptoms of the infection, but did not identify any organisms or infection resolution dates. There was no evidence of any tracking of infections in the facility for October 2015, November 2015, or December 2015. During interview on 12/2/15, at 1:15 p.m. support staff (SS)-A stated she used a report generated from the facilities electronic medical records to gather data regarding resident antibiotic use. She stated she does this quarterly and then gave the the information to the director for nursing (DON) to review.	F 441	F 441 Infection control to prevent spreading; the facility will establish and maintain an infection control program to maintain a safe environment for all residents to prevent the development and transmission or disease and infection. The infection control program will investigate, control, and prevent infections in the facility. The facility will maintain a record of incidences and corrective actions related to infections. The facility will have infection control logs that indicate tracking of infections, which require treatment using antibiotics. The log will indentify resident names, the date the antibiotic was started and completed and which antibiotic was used. The log will further indentify organisms and infection resolution date. Medical Director will review on a quarterly basis in QAPI and discuss infection control treads. Medical Director will sign off on all infection control logs at the quarterly QAPI meeting. Staff education was provided to all nurses in regards to our infection control process this was completed on 12/21/15. DON/ADON will ensure that the facility will	

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(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 441	Continued From page 50 During interview on 12/3/15, at 1:58 p.m. the DON stated SS-A compiles information on residents who have an infection. DON stated she looked for trends in infections from quarter to quarter and watch's for patterns and trends between residents and employees. She stated she spoke with staff daily regarding infections and asked about changes, however, there was no evidence of ongoing surveillance, tracking, or summarizing of infections or organisms to identify if there is a pattern. DON stated the facility should be tracking organisms. A facility policy labeled Oak Terrace Health Care Center of Gaylord, L.L.C. Infection Control dated June 2012, indicated in order to detect outbreaks early and monitor the effectiveness of these policies: surveillance of cultures obtained for clinical reasons should be reviewed regularly to determine if nosocomial transmission has occurred.	F 441	be tracking organisms and the resolution of infections. 12/18/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/03/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	**640 THIRD STREET** **GAYLORD, MN 55334**

(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
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 03, 2015. At the time of this survey, Building 01 of Oak Terrace Health Care Center was found to be 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 Occupancies. Building 01 of Oak Terrace Health Care Center was constructed in 1974, is one-story in height, has a full basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 48 beds and had a census of 41 at time of the survey.	K 000		

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

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

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245473	A. BUILDING **02 - 2008 ADDITION** B. WING _____	**12/03/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK TERRACE HEALTH CARE CENTER	**640 THIRD STREET GAYLORD, MN 55334**

(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
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 03, 22015. At the time of this survey, Building 02 of Oak Terrace Health Care Center was found to be 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 Occupancies. Building 02 of Oak Terrace Health Care Center was constructed in 2008, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 48 beds and had a census of 41 at time of the survey.	K 000		

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

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