#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: TNOZ

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PAR	T I - TO BE COMPLETE	D BY THE STATE	SURVEY AGENCY	Facility ID: 00109
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245465  2.STATE VENDOR OR MEDICAID NO.     (L2) 668340100	3. NAME AND ADDRESS OF (L3) COMMUNITY MEM (L4) 410 WEST MAIN STU (L5) OSAKIS, MN	IORIAL HOME	(L6) <b>56360</b>	4. TYPE OF ACTION: 7 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER C. 01 Hospital 05 HH		02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other  8. Full Survey After Complaint
6. DATE OF SURVEY 1/14/2015 (L34)  8. ACCREDITATION STATUS: (L10)  0 Unaccredited 1 TJC 2 AOA 3 Other	02 SNF/NF/Dual 06 PR 03 SNF/NF/Distinct 07 X-F 04 SNF 08 OP	Ray 11 ICF/IID	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30
11. LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12. Total Facility Beds 50 (L18)  13. Total Certified Beds 50 (L17)	10.THE FACILITY IS CERTII  X A. In Compliance With  Program Requirement Compliance Based Or	ts n: POC th Program	And/Or Approved Waivers Of The  2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) X 5. Life Safety Code  * Code: A, 5*	Following Requirements:
14. LTC CERTIFIED BED BREAKDOWN  18 SNF 18/19 SNF 19 SNF  50	ICF	IID	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38) (L39)  16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE	(L42) SHOW LTC CANCELL ATION D	(L43)		
17. SURVEYOR SIGNATURE	Date :	, ALL).	18. STATE SURVEY AGENCY APA	PROVAL Date:
Mary Rogers, HPR Social Work Sp		5 (L19)		orcement Specialist 02/13/2015 (L20)
PART II - TO	BE COMPLETED BY H	` ′	OFFICE OR SINGLE STAT	
19. DETERMINATION OF ELIGIBILITY  _X 1. Facility is Eligible to Participate  2. Facility is not Eligible  (L21)	20. COMPLIANCE RIGHTS ACT:			al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGREEM  OF PARTICIPATION BEGINNING  04/01/1987  (L24) (L41)		GREEMENT ING DATE	26. TERMINATION ACTION:  VOLUNTARY 00  01-Merger, Closure  02-Dissatisfaction W/ Reimbursemen	05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: 27. ALTERNATI A. Suspension		14)	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE: (L28)	9. INTERMEDIARY/CARRIER 1		30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)	2. DETERMINATION OF APPRO 01/23/2015	OVAL DATE (L33)	DETERMINATION APPROV	VAL

	UMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00109

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24-5465 Page #2

**∖**□

On 11/24/2014, an extended survey resulted in an IJ being called on 11/19/2014 at 4:19pm. It was removed 11/24/2014 at 1:07pm however noncompliance continued at a lower level. This Department recommended to CMS RO imposition of Civil Money Penalties (CMPs) for tags sited at F224, F225, and F226. The facility was not given an Opportunity ro Correct.

On 1/14/2015 CMS informed the facility of imposition of CMP effective 11/19/2014, and Mandatory Denial of Payment (DPNA) effective 2/14/2015, and subsequent loss of NATCEP due to Mandatory DPNA.

On 1/14/2015 the Minnesota Department of Public Health completed a Post Certification Revisit (PCR) finding that the facility had corrected the deficiencies found pursuant to the standard survey completed 11/24/2014. This Department therefore recommended to CMS RO that Mandatory DPNA be rescinded, and subsequent NATCEP loss likewise rescinded. CMS concurred. Effective 12/19/2014, the facility is certified for 50 skilled nursing facility beds.

The facility's request for a continuing waiver involving the deficiency(ies) cited under K067, corridors as plenum, at the time of the November 24, 2014 extended survey has been forwarded to CMS for their review and determination.



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245465 Electronically delivered January 28, 2015

Mr. David Carlson, Administrator Community Memorial Home 410 West Main Street Osakis, Minnesota 56360

Dear Mr. Carlson:

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 19, 2014 the above facility is certified for or recommended for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

Your request for waiver of has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K067: Corridors as Plenum.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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

Community Memorial Home January 28, 2015 Page 2

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 Licensing and Certification Program

Health Regulations Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered January 28, 2015

Mr. David Carlson, Administrator Community Memorial Home 410 West Main Street Osakis, Minnesota 56360

RE: Project Number S5465025

Dear Mr. Carlson:

On December 10, 2014, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective December 15, 2014. (42 CFR 488.422)

On January 14, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per day civil money penalty of \$6050.00, effective November 19, 2014. (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of \$200.00, effective November 24, 2014. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 24, 2015. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on November 24, 2014. The most serious deficiency was found to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required.

On January 14, 2015, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on November 24, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 19, 2014. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on November 24, 2014, as of December 19, 2014.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state

Community Memorial Home January 28, 2015 Page

monitoring effective December 19, 2014.

However, as we notified you in our letter of December 10, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 24, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of January 14, 2015:

- Per day civil money penalty of \$6050.00, effective November 19, 2014 be discontinued as of November 23, 2014, for a total amount of \$30,250.00. (42 CFR 488.430 through 488.444)
- Per instance civil money penalty of \$200.00, effective November 24, 2014. (42 CFR 488.430 through 488.444)
- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 24, 2015 be rescinded as of December 19, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Your request for a continuing waiver involving the deficiency(ies) cited under K067 at the time of the November 24, 2014 extended survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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 Licensing and Certification Program

Health Regulations Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245465	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/14/2015
Name	of Facility		Street Address, City, State, Zip Code	
CC	MMUNITY MEMORIAL HOME		410 WEST MAIN STREET	
			OSAKIS, MN 56360	

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

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
•	F0224 483.13(c)		Correction Completed 12/18/2014		ID Prefix Reg. # LSC	483.13(c)(1)(ii)-(ii	ii), (c)(2) -	Correction Completed 12/18/2014 (4)		Reg. #	F0226 483.13(c)		Correction Completed 12/18/2014
•	F0241 483.15(a)		Correction Completed 12/18/2014		ID Prefix Reg. # LSC	492 45(b)(6)		Correction Completed 12/15/2014			F0280 483.20(d)(3), 48		
ID Prefix Reg. # LSC			Correction Completed 12/19/2014		ID Prefix Reg. # LSC	F0312 483.25(a)(3)		Correction Completed 12/18/2014		Reg. #	F0323 483.25(h)		Correction Completed 12/12/2014
	400.05(:)		Correction Completed 12/18/2014			492 25(1)		Correction Completed 12/16/2014		Reg. #	F0371 483.35(i)		Correction Completed 12/11/2014
ID Prefix Reg. #			Correction Completed 12/05/2014		ID Prefix Reg. #			Correction Completed 12/16/2014		ID Prefix Reg. #	F0441 483.65		Correction Completed 12/05/2014
Reviewed By	/ Re	viewed E	Зу	Dat		Signature						Date: 1/14/2	2015
Reviewed By		yiewed E		Da		Signature	of Surve					Date:	-

Form Approved OMB NO. 0938-0390

#### Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

ì	Provider / Supplier / CLIA / dentification Number 45465	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 1/14/2015
Name of	Facility		Street Address, City, State, Zip Code	
COM	IMUNITY MEMORIAL HOME		410 WEST MAIN STREET OSAKIS, MN 56360	

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

(Y4) Item		(Y5)	Date	(Y4)	ltem		(Y5)	Date	(Y4)	Item		(Y5)	Date
			Correction					Correction					Correction
ID Desfer	E0.40E		Completed	l	D 6	F0.400		Completed		ID Dester	F0.400		Completed
ID Prefix			12/16/2014	"	O Prefix	F0490		12/18/2014		ID Prefix	F0493		12/18/2014
Reg. # LSC	483.70(h)				Reg. #	483.75				Reg. # LSC	483.75(d)(1)-(2)		_
				-	LSC				<u></u>	LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0501		12/18/2014	II	O Prefix	F0514		12/18/2014		ID Prefix	F0520		12/18/2014
Reg.#	483.75(i)				Reg. #	483.75(I)(1)				Reg. #	483.75(o)(1)		
LSC			•		LSC					LSC			_
Davisous d D		Parisaved		Bata									
Reviewed By		Reviewed E		Date		Signature of	of Surve					Date:	
State Agenc	у	JS	S/KJ	1	/28/2	015		29437				1/14	4/2015
Reviewed B	y ——	Reviewed E	Зу	Date	:	Signature of	of Surve	yor:				Date:	
CMS RO													
Followup to	Survey Compl	eted on:									a Summary of		
	11/24	1/2014				Une	correcte	d Deficiencies	s (CM	S-2567) Sent	to the Facility?	YES	NO

#### 

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

	(Y5	Date	(Y4) Item	(Y5)	Date	(Y4) I	tem	(Y5)	Date	
		Correction			Correction				Cor	rection
ID Drofiv	20255	Completed 12/18/2014	ID Drofiv	20570	Completed		ID Drofiv	20025		mpleted 18/2014
ID Prefix		12/18/2014	ID Prefix		12/18/2014		ID Prefix			
-	MN Rule 4658.0070	_		MN Rule 4658.0405 Subp.	4		•	MN Rule 4658.0450	Subp. 1 A-	
LSC		-	LSC				LSC			
		Correction			Correction				Cor	rection
		Completed			Completed					npleted
ID Prefix	20830	12/19/2014	ID Prefix	20920	12/18/2014		ID Prefix	20965		18/2014
Reg. #	MN Rule 4658.0520 Subp.	1	Reg. #	MN Rule 4658.0525 Subp.	6 B		Reg. #	MN Rule 4658.0600	Subp. 2	
LSC		-	LSC				LSC			
									_	
		Correction			Correction					rection
ID Prefix	21015	Completed <b>12/11/2014</b>	ID Prefix	21230	Completed <b>12/18/2014</b>		ID Prefix	21385		npleted 05/2014
Rea.#	MN Rule 4658.0610 Subp.	7	Rea. #	MN Rule 4658.0700 Subp.	2 B		Rea.#	MN Rule 4658.0800	Subp. 3	
LSC		<del>-</del> -	LSC				LSC			
		Correction			Correction				Cor	rection
		Completed			Completed					npleted
ID Prefix	21525	12/05/2014	ID Prefix	21530	12/16/2014		ID Prefix	21540		16/2014
Reg.#	MN Rule 4658.1305 A.B.C		Reg. #	MN Rule 4658.1310 A.B.C			Reg. #	MN Rule 4658.1315	Subp. 2	
LSC		-	LSC				LSC			
		Correction			Correction				Cor	rection
		Completed			Completed					npleted
ID Prefix	21665	12/16/2014	ID Prefix	21705	12/15/2014		ID Prefix	21805		18/2014
Rea.#	MN Rule 4658.1400	_	Reg. #	MN Rule 4658.1415 Subp.	6		Rea.#	MN St. Statute 144		
LSC		-	LSC				LSC			
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:			Da	ate:	
State Agency	JS/I	ζJ	1/28/2015	5	24	1937			1/14/	2015
Reviewed By	Reviewed	-	Date:	Signature of Surve				Da	ate:	

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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

		(Y5)	Date	(Y4) It	em		(Y5)	Date	(Y4)	Item	(Y5)	Date
		(	Correction					Correction				
ID Deaf	24950		Completed	15	Drefit	22002		Completed				
ID Prefix			12/18/2014			22000		12/18/2014				
-	MN St. Statute	144.651 Sub	d. 1			MN St. Statut	te 626.557 Sul	bd.				
LSC				-	LSC				+			
	ı											
Reviewed By	,	Reviewed B	y	Date:		Signa	ture of Surve	yor:			Date:	
Reviewed By State Agency		Reviewed By			/2015			yor: 24937				k/2015
	,		2015		/2015	5		24937				1/2015
itate Agency	,	1/28/2	2015	1/28	/2015	5	2	24937			1/14	1/2015
State Agency Reviewed By CMS RO	,	1/28/2 Reviewed B	2015	1/28	/2015	Signa	2 ture of Surve	24937 yor:	Deficie	encies. Was a Summary of	1/14	k/2015

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: TNOZ Facility ID: 00109

		10 22 00::111		1112	E SCH (ET HOEK)		Tuellity 12. 00109
MEDICARE/MEDICAID PROVIDE     (L1) 245465  2.STATE VENDOR OR MEDICAID N		3. NAME AND AL (L3) COMMUNI (L4) 410 WEST M	TY MEMORI MAIN STREE	AL HOME		4. TYPE OF ACTION 1. Initial 3. Termination	ON: <u>2 (L8)</u> 2. Recertification 4. CHOW
(L2) <b>668340100</b>		(L5) OSAKIS, M	N		(L6) <b>56360</b>	5. Validation 7. On-Site Visit	6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEO 05 HHA	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey Afte	
6. DATE OF SURVEY 11/24 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	<b>L/2014</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END	ING DATE: (L35)
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia	nce With		And/Or Approved Waivers O	f The Following Requirer	nents:
To (b):			equirements e Based On:		2. Technical Personne		
12.Total Facility Beds	<b>50</b> (L18)	•	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SI 5. Life Safety Code	7. Medical D NF)8. Patient Roo 9. Beds/Roor	om Size
13.Total Certified Beds	<b>50</b> (L17)	X B. Not in Com Requirement	npliance with Progents and/or Appli			(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
50					<b>3</b> , ( )		
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION :	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Holly Kranz, H	FE NE II	1	2/29/2014	(L19)	Kate JohnsTon, En	forcement Spec	<u>riali</u> st 01/23/2015 <sub>(L20)</sub>
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY	
19. DETERMINATION OF ELIGIBIE	JTY		IPLIANCE WITI	H CIVIL	21. 1. Statement of Fina		
X 1. Facility is Eligible to F	Participate	RIGE	HTS ACT:		3. Both of the Abov	rol Interest Disclosure Stm e:	(HCFA-1515)
2. Facility is not Eligible	(L21)						
	(==-)						
22. ORIGINAL DATE	23. LTC AGREE!	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION		(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY 0	<del></del>	
04/01/1987	<b>7.40</b>				01-Merger, Closure 02-Dissatisfaction W/ Reimburs		Meet Health/Safety Meet Agreement
(L24)	(L41)	VE GANGEIONG	(L25)		03-Risk of Involuntary Terminati	on	Weet rigicomene
25. LTC EXTENSION DATE:	27. ALTERNATI  A Suspension	of Admissions:			04-Other Reason for Withdrawal	OTHER 07-Provid	ler Status Change
	The Buspension	. 0114444	(L44)			00-Active	<del>-</del>
(L27)	B. Rescind St	ispension Date:					
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	LDATE			
	(I 22)	01/23/2015		(L33)	DETERMINIATION APP	DOWAL	
	(L32)			(133)	DETERMINATION APP	KUVAL	

DEPARTMENT OF HEALTH AND HUMA	NI CED VICEC
DEPARTMENT OF HEALTH AND HUMA	IN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY ID: 70EO Facility ID: 00109

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24-5465 Page #2

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On 11/24/2014, an extended survey resulted in an IJ being called on 11/19/2014 at 4:19pm. It was removed 11/24/2014 at 1:07pm however noncompliance continued at a lower level. This Department recommended to CMS RO imposition of Civil Money Penalties (CMPs) for tags cited at F224, F225, and F226. The facility was not given an Opportunity to Correct.

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The facility's request for a continuing waiver involving the deficiency(ies) cited under K067 at the time of the November 24, 2014 extended survey has been forwarded to CMS for their review and determination.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Submitted December 10, 2014

Mr. David Carlson, Administrator Community Memorial Home 410 West Main Street Osakis, Minnesota 56360

RE: Project Number S5465025

Dear Mr. Carlson:

On November 24, 2014, an extended 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not

immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

### REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on November 24, 2014, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

#### **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 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320)223-7343

Fax: (320)223-7365

#### NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective December 15, 2014. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V

### Office for imposition:

- Per instance civil money penalty for the deficiency cited at F0224. (42 CFR 488.430 through 488.444)
- Per instance civil money penalty for the deficiency cited at F0225. (42 CFR 488.430 through 488.444)
- Per instance civil money penalty for the deficiency cited at F0026. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

### SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Community Memorial Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 24, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

### **APPEAL RIGHTS**

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality

of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

### 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 remedy be imposed:

• 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. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

## 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 February 24, 2015 (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 May 24, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Minnesota Street, Suite 145

> St. Paul, Minnesota 55101-5145 Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 12/23/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND ILAN O	F CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDII	NG	COMPLETED		
		245465	B. WING _		11/24	1/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
COMMUN	NITY MEMORIAL HON	ΛE		410 WEST MAIN STREET OSAKIS, MN 56360			
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F 000	INITIAL COMMENT	<sup>-</sup> S	F 00	00			
F 224 SS=L	Department of Hea through November in an Immediate Je related to the facility assess, investigate the administrator arimplement interventree from abuse whotential for harmonotified of the immediate 19 2014, at 4:19 p. 19, 2014, at 4:19 p. November 24, 2014 noncompliance remseverity level, with particular and 21, 2014.  The facility's plan of as your allegation of Department's accepenrolled in ePOC, yat the bottom of the form. Your electron be used as verificate Upon receipt of an on-site revisit of you validate that substate regulations has been your verification.  483.13(c) PROHIBI	rained at a pattern scope and potential for actual harm.  If was conducted by the ment of Health on November  If correction (POC) will serve from the potance. Because you are rour signature is not required first page of the CMS-2567 aic submission of the POC will ion of compliance.  If correction (POC) will serve from the potance will in acceptable electronic POC, an aur facility may be conducted to intial compliance with the en attained in accordance with	F 23	24	1	2/18/14	
LABORATOR\	DIRECTOR'S OR PROVID	 ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	(X	6) DATE	
	ically Signed			•••		2/20/2014	
	, 3				•		

(X2) MULTIPLE CONSTRUCTION

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 224	policies and proce- mistreatment, negl and misappropriati	evelop and implement written dures that prohibit ect, and abuse of residents on of resident property.	F 224				
	by: Based on interview facility administration residents (R52, R5 made allegations of mistreatment were up and resolution to from occurring. The of staff mistreatment, and developing interverse abuse, resulted in 36 residents current remained at risk of and/or mistreatment.  The immediate jeed 4:19 p.m. when the comprehensively a implement interverse were involved in all mistreatment, were 11/19/14, at 4:19 prodirector of nursing immediate jeopard currently residing i removed on 11/24/	pardy began on 11/19/14, at		Vulnerable adult reports were filed to state agency on residents #47 and 11/19/14 and reports filed on reside #52, 58, and 44 on 11/21/14. All reports thoroughly investigated and the results of those investigations were to the state agency within the regular requirements of the 5 working days Internal facility investigation led to the termination of 2 employees. One employee was suspended pending training on resident transfers and one employee required additional deme education. The two employees that received further education were allowed further education were allowed further education were allowed further the education had been completed. All above resident affected had care plans reviewed. Mood/behavior focus charting was initiated and completed on all reside #52, 58, 44, 47 and 12 to monitor focus charges in psychosocial wellbeing. concerns or effects from the filed rewere noted.	#12 on ents ports he filed ation he further ne entia bwed to ad as No ents por any No		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 224	and severity level, village an	dated 11/20/14, identified ghip joint replacement, in the pelvic region and thigh.  Jamum Data Set (MDS) dated R52 had no cognitive quired extensive weight from two staff for transfers.  Jamum R52 ago, a male nursing assistant on the arm during a transfer to the bed, and was so rough ne nightstand table. R52 and screamed from the transfer was so rough. R52 and the incident to the registered anager, but no one from the to her about the incident.  Jamum R52 are darked from the transfer was so rough. R52 and screamed from the transfer was so rough. R52 and the incident to the registered anager, but no one from the to her about the incident.  Jamum R52 are darked from the to her about the incident.  Jamum R52 stated the NA had to her since this incident, but way," from that NA if he were to are again due to the pain he	F 22	Interviews conducted with all no on 11/19/14 and interviews conwith all residents in the facility of to identify other potential cases neglect or mistreatment. During interviews, one incident was replaced incident was immediately report agency. The incident was then investigated per Vulnerable Addand procedures. Staff member was suspended and received a training on transfers prior to hele work schedule. Safety Risk assigner completed on all residents plan changes were adjusted.  Zero Tolerance statement initiate facility administrator. Vulnerable Policy and Procedure was review revised to include the protection residents during an alleged act abuse/neglect. Changes included immediate removal and/or suspalleged perpetrator. All licensed received training and direction of submit an alleged report of abustate agency. An in-service traitrained consultant was conduct on Vulnerable Adult and Abuse education included reviewing the copy of the updated Vulnerable Abuse and Prevention Plan, and discussion on different types of	ducted in 11/20/14 of resident president president ported. It Policy involved dditional return to essments and care and care are seed by expension of lessential properties of the presion of lessential properties and care are are seed by expension of lessential properties and care are are are are are are are are are	
	transfer.  During interview or stated she was awa	ast time he assisted her to 11/18/14, at 3:35 p.m. DON are of R52's allegation of a ng her roughly, and she had		including examples of physical, and emotional abuse. The staff educated on the new disciplinal procedures during reports of all abuse. The new Abuse Protocowere also reviewed and the cor	were also ry eged I folders	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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F 224	incident. The DON made to the SA regadministrator was allegation, and their investigation determines the NA. SS-A state and reported R52 to the NA. SS-A state and reported R52 to the incident, however documented the infindings of the intellection of the incident, and the incident incident incident incident.	R52 and the NA about the confirmed no report had been garding the allegation, The not notified immediately of the re was no documented mining what had happened.  In 11/18/14, at 6:29 p.m. social the DON were interviewed implaint of rough treatment by d R52's family had called her was upset about rough during a transfer. SS-A stated he NA and charge nurse about ver, SS-A stated she had not vestigation regarding the roiews, and she did not report ency or administrator. SS-A ey had spoken with R52 about he resident did not experience didn't believe the allegation of potential abuse, neglect, or determined no report needed state agency. SS-A and DON to documentation regarding any erviews, and the NA who was reatment of R52 had no further ng to ensure further resident	F 2	them were discussed at the director of nursing conduct meetings to review Vulnera and procedures. Policy and Morning Standup, Weekly Quality Assurance were revised to include added coand review of incidents and Adult trends. Grievances a will be reviewed on a daily the Morning Standup Meeti with the IDT team. All unregrievances will be reviewed the QA team for further reviewed direction for resolution. An was developed and put into Director of Nursing. All incireviewed during Morning Sthen the incident will be plarecord. The log will be reviewed during IDT and quarterly with assure that all incidents are investigated and complete. Grievance form was developed onto place. Staff were eductive director of nursing on the log proper use of the new facility forms.	ed 2 staff able Adult policy d Procedures of IDT, and viewed and ommunication d Vulnerable nd or incidents basis during ing and weekly esolved d quarterly with riew and incident log o place by the dents will be tandup and aced on the log ewed weekly ith QA to e fully A new ped and put cated by the ocation and		
	stated she was aw month ago regarding a NA. RN-B stated completed with the R52 roughly, as we documented any or reported R52's according	n 11/18/14, at 3:27 p.m. RN-B are R52 had concerns about a ng being transferred roughly by interviews had been NA accused of transferring lell as with R52, but she had not f the investigation, nor had she cusation of rough treatment to r state agency. RN-B was not		Staff education of Vulnerable and Procedure will continue QAPI. During resident cour 12/18/14, a review of Vulne Policy and Procedure and procedure took place. All II minutes will be reviewed que QA team to review incident trends of abuse. Upon this	e through ncil on erable Adult grievance DT weekly log uarterly with the s and potential		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 224	aware of any monit completed for the I and RN-B did not f resident mistreatm experience any injumisunderstanding.  During interview or administrator state would be handled a would work with the and would only be mistreatment, for effom the rough transure if he was mithe rough transfer he knew the NA ac with R52, and he dintentionally mistre R58's quarterly MER58 had severely i required assistance eating.  Review of a facility dated 8/7/14, indicating room and N. "You have to eat, the so there is no reas was observed by N pinching them toge and pushed a spoostated, "Now eat!" licensed practical reported it to RN-B bottom of the Prob "Above issue was 8/8/14, by the RN of the side of the RN-B bottom of the RN-	toring that was being NA involved in the allegation, eel this met the definition of ent because R52 did not ary and felt it was more of a between R52 and the NA.  In 11/19/14, at 12:13 p.m., the d rough transfers of a resident as a complaint and facility staff the family to resolve the concern, reported if it rose to the level of example, an injury resulted asfer. The administrator was hade aware of the allegation of with R52, however, he stated cused of the rough transfer id not believe the NA would	F 2	revisions and/or staff educe implemented indicated via written action plan. New er packets and education we include revisions to Vulner and procedures. Quarterly interviews will be conducted services or her delegate to identification of any actual issues. Quarterly QA meet 12/16/14. New changes re Vulnerable Adult Policy and were reviewed with the meet The Director of Social Services for monitoring allegations of abuse/negle misappropriation are report investigated according to for The Administrator will be refacility compliance.  Corrective action for this tacompleted on 12/18/14.	proscribe mployee h re updated able adult resident d by social facilitate or potenti ing occurr elated to the d Procedu edical direct vices will be that all ct or red and facility polices esponsible	ed hire d to to policy al the fal red on he ctor.	

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F 224	incident." There was the mistreatment to to the state agency During interview on stated she remember R58 and NA-D. RN apologized and rectreat R58 the ways was nothing further stated she had no fincident, and it was administrator or stanot believe there wand R58 had no on incident. During interview on stated when she spincident with R58, N wrong, and NA-D sagain. DON stated re-education or corbeing monitored to other residents, the of the incident, and state agency. DON mistreatment becaus NA-D knew her act apologized. R44's annual MDS resident had diagnor disease, had mode required assistance was kept in the DO incident involving R indicated on 11/3/1 dining room in his was server was	as no further investigation of R58, and it was not reported.  11/19/14, at 1:30 p.m. RN-B pered the incident between N-B stated NA-D had ognized she was wrong to the did, so the facility felt there they needed to do. RN-B urther investigation of the not reported to the agency because they did as any abuse that took place going effects from the NA-D knew how she acted was tated it would not happen NA-D did not receive rective action, NA-D was not observe her interaction with re was no further investigation it was not reported to the I did not feel this was abuse or use R58 was not harmed, and ions were not acceptable and dated 10/2/14, indicated the oses including Alzheimer's rately impaired cognition, and of one staff with ADL's, and	F 2	224		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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F 224	document indicated dining room should hungry and wanted RN-C in front of R4 then, "You can get down!" NA-D left I wheelchair and wal R44 to get a snack contained no further incident with NA-D. During interview on stated NA-D was vere R44 while they were room on 11/3/14. I being disrespectful to the DON. On 11 DON had a meeting instructed by DON supervisors needed to work on her abilit with her co-workers further training or machine in the residents. During interview on stated NA-D had as were wrong and wo stated NA-D did no corrective action, we residents to ensure there was no further incident been report stated she did not for this incident. A accusations of residents in the residents of the residents of the cause R44 did not for this incident. A accusations of residents of the residents of the cause R44 did not for this incident. A accusations of residents of the residents of the cause R44 did not for this incident. A accusations of residents of the residents of the cause R44 did not for this incident. A accusations of residents of the resid	In NA-D very loudly stated the be open because R44 was to eat. NA-D stated loudly to 4, "in a disrespectful manner," him [R44] up when he lays R44 sitting in the hallway in his ked away, and RN-C assisted. The untitled document or investigation regarding this are investigation of RN-D was an infront of R44 she reported it are investigation. The investigation in the investigation of R44 and are investigation, nor had the ted to the state agency. Done in the investigation, nor had the ted to the state agency. Done in the investigation, nor had the ted to the state agency. Done in the investigation in the facility monitor to prevent further	F 2	24		

-	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			X3) DATE SURVEY COMPLETED	
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F 224	On the same untitle written by RN-C regard resident mistre "What I felt as dem meal, stating rudely herself, even thoug more assistance to follow up with NA-D being rude to the reinterviews with staff who the resident was R47's Admission Rediagnoses of Alzheincontinence. R47' 8/18/14, identified Fimpairment, was included, required estaff for bed mobilit on staff for toileting During interview on member (FM)-A stafive months ago, shinto the hallway whiprovided personal of R47 moaning, and on her. FM-A state curtain, and witness R47 on her side, ar with her elbow, whie "Pain." FM-A stated she has the incident from the followed up with her During interview on verified FM-A had resident form the provided FM-A had resident form the provided form the followed up with her provided form the followed up with the foll	ad document dated 11/3/14, garding concerns with NA-D atment, indicated NA-D, eaning to a resident at noon that a resident could feed herself." There was no regarding RN-C concerns of esident. During multiple for no one was able to recall as NA-D had been rude to.  Becord dated 11/11/14, included mer's disease and urinary sequarterly MDS dated R47 had severe cognitive continent of bowel and extensive assistance of two and was totally dependent and personal hygiene.  11/18/14, at 11:19 a.m. family the dwille visiting R47 about the stepped out of R47's room the stepped out of R47's room the two nursing assistants exares for R47. FM-A heard went into R47's room to check dishe pulled back the privacy sed an unidentified NA holding and the NA was leaning on R47 this made her upset, and cident to SS-A right away. In the decility, and no one had		224			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		245465	B. WING		11	11/24/2014		
	PROVIDER OR SUPPLIER	ЛЕ		STREET ADDRESS, CITY, STATE, 410 WEST MAIN STREET OSAKIS, MN 56360	<u> </u>			
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F 224	while a NA was hold personal cares. SS much about the inc involved more in the the DON would hav regarding the incide "Some of the things documented, and so During interview on stated she had nevel between R47 and a causing her pain, a During another inte a.m., SS-A stated so reported the incider RN-A because DON RN-A was in charge talked to the two stap providing R47 cares feel that they were none-time thingThe appear to be report no documentation of incident because, "resident." SS-A stated that they were none-time thingThe appear to be report no documentation of incident because, "resident." SS-A stated that they were none-time thingThe appear to be report no documentation of incident because, "resident." SS-A stated that she need the administrator, and opolicy that she need the administrator if SS-A could not recall accused of being rounding would be in because it was not mistreatment to R4	ding R47 on her side during A stated she did not know ident, because the DON was a investigation. SS-A stated re any documentation ent, however, SS-A stated, a reported [by family] are ome are not."  11/19/14, at 8:48 a.m., DON er heard about the incident a staff member leaning into her and had no idea what occurred.  Inview on 11/19/14, at 8:52 he now recalled she had not with R47 and the NA to N was gone that day, and e. SS-A stated she and RN-A aff members involved in a sthat day, and, "They did not be being rough It was a gre wasn't a lot to it It didn't able." SS-A stated there was no injury to the red, "No form was filled out. The other incident to the did not know if it was in their ded to report the incident to it was not considered abuse. The employees were ough with R47, and stated the employees personal file determined there was any	F 2	224				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
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F 224	stated when a com should review the ir reportablewhoeve up with the family reportIf you report four or five times a want to talk to the fathere is a grievance a concern the nurse DON verified there regarding the report The DON stated the after a complaint by reaction to that care required monitoring mistreatment of resulting interview on administrator was a understanding ware of the mistre R47's family memb "The policy says the immediately. I don't injury" The admin looked at the grievanot experience any level of a reportable stated when they have the facility felt becawomen, she was gowith cares, and he misunderstanding.  R12's Admission Rediagnoses of demechronic kidney disedated 10/9/14, identifications.	plaint is received, the facility neident, "To see if it's er receives the concern follows You don't want to over the everything, you could report week." DON stated she would amily, resident, and staff first if everything, and if there was everything, and if there was everything to focus charting. Was no documentation the grievance involving R47. The facility protects a resident of equiver." DON verified no staff in the last 7 months related to sidents.  11/19/14, at 11:42 a.m., the mable to clearly state if he was atment allegation made by er. The administrator stated, at I need to be made aware think it was a report of instrator stated the facility ance, and determined R47 did harm, so it didn't rise to the experiment in the last of the experiment. Administrator and spoke about this incident, use R47 was a heavier oring to require "extra support" believed it was just a secord dated 1/18/08, included intia, depressive disorder, and ase. R12's quarterly MDS tified R12 had severe int, and required extensive staff	F 2	224				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	ЛE		4	STREET ADDRESS, CITY, STATE, ZIP CODE 110 WEST MAIN STREET DSAKIS, MN 56360		
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F 224	offer R12 toileting enight, and PRN (as During interview on FM-B stated, "Some residents." FM-B stated, "Some wants to go to their her to the bathroom, and stated she reported providing toileting for well as the concern RN-D.  A facility Grievance. 11/12/14, indicated concerns regarding including staff being reminding her of the Documentation of F"Reminded staff to changes; spoke wit The grievance/com DON and registered no further investigal regarding staff treat During interview on unidentified visitor at they had overheard to use the restroom	ed 10/20/14, directed staff to every two hours, with rounds at needed) per resident request.  11/18/14, at 3:41 p.m. R12's every two hours, with rounds at needed) per resident request.  11/18/14, at 3:41 p.m. R12's every two hours are rude to the stated R12 had the start of etimes she calls out and estroom, but staff will not take and tell her she was just in the staff walk away. FM-B her concerns of staff not for R12 when requested, as so frude staff members to complaint form dated FM-B had expressed staff treatment of R12, grimpatient with R12 when every last toileting activity. The facility Follow-up indicated, alert nurse of behavior her staff; passed on in report" plaint form was signed by dinurse RN-D, and there was tion of FM-B's complaints the facility stated on 11/7/14, R12 ask NA-J for assistance . NA-J stated to R12, "I told	F 2	224	,		
	be quiet!" The visit anyone at the facilit	s done, I would help you. Now or stated she had not told y about this, but stated this mfortable as she felt the staff					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
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F 224	stated the reported mistreatment involved documented on the 11/12/14, had not be administrator or the investigation of the any staff were interregarding toileting of the any staff were interregarding toileting of the any staff were interregarding toileting of the facility mistreatment, it would alter the facility mistreatment for family complaint Problem/ Resolution if there were any constant was not aware mistreatment to result and was not aware of those injury and those we "Misunderstandings RN-B stated if she concerns with staff will talk to the staff and come to a concaculation isn't document of the facility mistreatment, it would be a state of the facility mistreatment, it would be approximately and the facility mistreatment, it would be approximately and the facility mistreatment, it would be approximately and the facility mistreatment and the	11/21/14, at 10:07 a.m. DON incident/ grievance of staff ring R12, which was grievance form dated een reported to the SA. DON had no incident, and could not verify if viewed or re-educated R12.  11/18/14, at 11:45 p.m. RN-B had an accusation of staff uld depend on the severity of nine the investigation, if it and if it would be documented. Eility had incident reports, used for falls or bruises/ skin ms, which could be filled out its, and also had forms called in forms, which could be used oncerns involving staff. RN-B been involved in making any agency in the last 7 months,	F 2	224			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
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F 224	a.m., SS-A stated to have a lot of grieval grievance form if a kind. SS-A stated i would talk to the act to the staff member the investigation the member had "done they would be suspresidents are proteinvestigation by, "Woomfort with that period investigation of grief investigation of grief investigation of alle "Watching to see if behavior" The Doresidents in the past to monitor for behavior allegations of staff stated the facility diallegations of staff documented, and setermined just by	ypically the facility doesn't nces, but staff can fill out the family had a concern of any f there was a grievance she liministrator and DON and talk r involved. SS-A stated if after e facility determined the staff something to the resident," ended. SS-A stated the cted during a facility atching the resident's level of erson [staff accused of stated if the resident was ember would be removed from	F 2	24					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
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F 224	being reported and system in place to in resident mistrea if any staff had a p not trained to use a concerns of reside had multiple forms grievance forms, a DON stated some binder in the socia employee files, and her office. The DO system to track resulting follow up in a.m. administrator involved in the investigate to the immediately, and rathe DON about resistated, "We commistrator the DON about resistated, "We commistrator the daministrator the daministrator the believed the facility investigation, report however, not all all "Result in injury." The was aware resistant aware the administrator immeresident mistreatmeresident mistr	to ensure all allegations were a investigated, nor was there a track and trend staff involved tment allegations to determine attern. DON stated staff were a certain form to document nt mistreatment, and the facility including incident reports, and problem/ resolution forms. of these forms were kept in a l workers office, some were in d some were in a file cabinet in N verified the facility had no sident mistreatment.  terview on 11/19/14, at 12:10 stated he felt like he was estigation process at the facility. Stated he would expect if there is resident mistreatment, the sten to the complaint, evaluate	F 2	224				

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		245465	B. WING			11/	24/2014
	NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME			STREET ADDRESS, CITY, STATE, 410 WEST MAIN STREET OSAKIS, MN 56360	ZIP CODE		
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F 224	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 14 report it [to the state agency]." The administrator verified no reports had been filed with the state agency in past 4 months, and there had only been a total of 3 reports made in the last 8 months, none of which had to do with staff mistreatment to residents. The administrator stated they have a very small facility, so the management feels like they know there staff very well, and they have no reason to believe any of their staff would mistreat any of the residents.  On 11/19/14, the facility submitted reports to the state agency regarding the above allegations of staff mistreatment for R52, R58, R44, R47 and R12. The investigations were submitted to the state agency on 11/21/14. Review of the investigations submitted on 11/21/14, for R52, R58, R44, R47 and R12, were found to be incomplete and did not include interviews with any other staff regarding resident mistreatment by the staff members involved, did not include any follow up interviews with family, nor did it indicate if the staff members accused of resident mistreatment had any prior accusations of resident abuse. DON was interviewed on 11/21/14, at approximetly 2:10 p.m. regarding the incomplete investigations submitted to the state agency on 11/21/14, for R52, R58, R44, R47 and R12. DON verified the investigations were not complete and lacked the above information. On 11/21/14, the facility completed further investigation reports to the state agency for R52, R58, R44, R47 and R12.  The IJ that began on 11/19/14, at 4:19 p.m., was removed on 11/24/14, at 1:07 p.m., when the facility completed the following interventions:		F 2	224			

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F 224	All staff were trained prevention policy, winstruction to staff of neglect.  An abuse protocoly beginning 11/21/14 instructions on how to the administrator packet is available.  All charge nurses were to report all allegating administrator and second documented invest.  All final investigation DON and reviewed.  All residents in the SS-A and the administrator and second reviewed.  The facility implement of the facility implement o	d on the facility abuse which included specific on recognizing abuse and packet was implemented, which included specific to report allegations of abuse and state agency. This to all staff.  were educated on responsibility ons of abuse to the state agency, and begin a	F 22	24			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 224	protection, investiga	ge 16 ent, internal reporting; resident ation and external reporting as y's revised Abuse Prevention	F 2	24			
F 225 SS=L	remained at a lowe	PORT	F 2	25		12/18/14	
	been found guilty of mistreating resident had a finding entered registry concerning of residents or mistal and report any known court of law against indicate unfitness for	ot employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a tran employee, which would be service as a nurse aide or the State nurse aide registry ties.					
	involving mistreatm including injuries of misappropriation of immediately to the a to other officials in a	esure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law d procedures (including to the ertification agency).					
	violations are thoro	evidence that all alleged ughly investigated, and must ential abuse while the rogress.					

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F 225	to the administrator representative and with State law (incleartification agence incident, and if the	age 17  Investigations must be reported or or his designated of the other officials in accordance duding to the State survey and y) within 5 working days of the alleged violation is verified tive action must be taken.	F 2	25			
	by: Based on intervier facility failed to rep state agency, and staff abuse, negled 8 residents (R52, I made allegations of failure of the facility place regarding all neglect, and mistrator and thoroughly investig Jeopardy (IJ) for a residing in the facility failed to rep the administrator and implement into were protected from residents were free administrator and notified of the immore residents in the factorial than the fac	1/19/14, at 4:19 p.m., when the		F225 Vulnerable adult reports were f state agency on residents #47 a 11/19/14 and reports filed on re #52, 58, and 44 on 11/21/14. Al were thoroughly investigated ar results of those investigations were to the state agency within the receptive requirements of the 5 working of Internal facility investigation led termination of 2 employees. On employee was suspended pendicationing on resident transfers ar employee required additional deceducation. The two employees received further education were return to work after the education been completed. All above residustments were required. Mood/behavior focus charting we initiated and completed on all re #52, 58, 44, 47 and 12 to monit changes in psychosocial wellbe concerns or effects from the file were noted.	and #12 on sidents reports d the rere filed gulation ays. to the eing further d one ementia chat allowed to an had dents ed. No ras esidents or for anying. No		

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F 225	Continued From pa	ge 18	F 225	5			
	diagnoses including scoliosis, and pain R52's quarterly Min 10/23/14, identified impairment and recebearing assistance  During interview on stated a few weeks (NA) grabbed her of from the wheelchai she hit her hip on the stated she, "Hollere pain," because the stated she reported nurse (RN) case me facility had spoke to the During another inte R52 again shared hereatment from a stand stated she thou when he assisted hit was like to be in provided cares she would, "Shy aw provide cares to he caused during the letransfer.  During interview on stated she was away and the stated she was away as a stated she was away and the stated she was away as a stated she was a stated she was away as a stated she was away as a stated she was a state	dated 11/20/14, identified ghip joint replacement, in the pelvic region and thigh.  January Data Set (MDS) dated R52 had no cognitive quired extensive weight from two staff for transfers.  11/17/14, at 3:34 p.m. R52 ago, a male nursing assistant on the arm during a transfer reto the bed, and was so rough ne nightstand table. R52 and screamed from the transfer was so rough. R52 and screamed from the transfer was so rough. R52 and the incident to the registered anager, but no one from the point her about the incident.  Triew on 11/8/14, at 2:53 p.m. her concerns of rough aff member during a transfer, ught the NA was too rough her and didn't understand what to her since this incident, but vay," from that NA if he were to ragain due to the pain he ast time he assisted her to		Interviews conducted with all nursi on 11/19/14 and interviews conducted with all residents in the facility on 1 to identify other potential cases of neglect or mistreatment. During reinterviews, one incident was report Incident was immediately reported agency. The incident was then investigated per Vulnerable Adult Fand procedures. Staff member investigated and received additraining on transfers prior to her rework schedule. Safety Risk assess were completed on all residents arplan changes were adjusted.  Zero Tolerance statement initiated facility administrator. Vulnerable AdPolicy and Procedure was reviewerevised to include the protection of residents during an alleged act of abuse/neglect. Changes include immediate removal and/or suspenalleged perpetrator. All licensed streceived training and direction on submit an alleged report of abuse state agency. An in-service training trained consultant was conducted on Vulnerable Adult and Abuse. The ducation included reviewing the hope of the updated Vulnerable AdAbuse and Prevention Plan, an indiscussion on different types of abincluding examples of physical, ve and emotional abuse. The staff we educated on the new disciplinary procedures during reports of alleger and procedures and procedures and proc	ted 1/20/14 resident sident red. to state Policy olved tional turn to sments nd care  by dult d and  sion of aff now to to the g by a for staff iis ard ult depth use rbal, ere also		

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F 225	made to the SA or a allegation, and ther investigation determ. During interview on service (SS)-A and regarding R52's couthe NA. SS-A state and reported R52 with the incident, howeved documented the investigation of the interview of the incident, and the incident	confirmed no report had been administrator regarding the e was no documented mining what had happened.  11/18/14, at 6:29 p.m. social the DON were interviewed implaint of rough treatment by d R52's family had called her was upset about rough luring a transfer. SS-A stated in NA and charge nurse about er, SS-A stated she had not vestigation regarding the views, and she did not report ency or administrator. SS-A ey had spoken with R52 about e resident did not experience didn't believe the allegation of potential abuse, neglect, or determined no report needed state agency. SS-A and DON or documentation regarding any erviews, and the NA who was reatment of R52 had no furthering to ensure further resident of occur.  11/18/14, at 3:27 p.m. RN-B are R52 had concerns about a ng being transferred roughly by interviews had been NA accused of transferring las with R52, but she had not the investigation, nor had she usation of rough treatment to restate agency. RN-B did not	F2	225	were also reviewed and the content them were discussed at the inservice director of nursing conducted 2 star meetings to review Vulnerable Adult and procedures. Policy and Proced Morning Standup, Weekly IDT, and Quality Assurance were reviewed a revised to include added communicand review of incidents and Vulnera Adult trends. Grievances and or include the Morning Standup Meeting and with the IDT team. All unresolved grievances will be reviewed quarter the QA team for further review and direction for resolution. An incident was developed and put into place be Director of Nursing. All incidents wireviewed during Morning Standup at then the incident will be placed on the record. The log will be reviewed we during IDT and quarterly with QA to assure that all incidents are fully investigated and complete. A new grievance form was developed and onto place. Staff were educated by director of nursing on the location aproper use of the new facility grievatorms.  Staff education of Vulnerable Adult and Procedure will continue through QAPI. During resident council on 12/18/14, a review of Vulnerable Adult and Procedure took place. All IDT week minutes will be reviewed quarterly will be reviewed quarterly and Procedure and grievance procedure took place. All IDT week minutes will be reviewed quarterly will	ce. The ff trolley lures of land cation able cidents ring weekly ly with log by the ll be and the log cekly put the land ance Policy holds ly log with the log with the ly log with the ly log with the light land land land land land land land land	

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		245465	B. WING		11/2	24/2014	
	PROVIDER OR SUPPLIER	ME	4	STREET ADDRESS, CITY, STATE, ZIP CODE 110 WEST MAIN STREET OSAKIS, MN 56360	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 225	administrator or stanot experience any more of a misunder the NA.  During interview on administrator stated would be handled a would work with the and would only be it rose to the level of an injury resulted fradministrator was a cofficient to the allegation of immediately after it stated he knew the transfer with R52, a would intentionally R58's quarterly MD R58 had severely in required assistance eating. Review of a facility	age 20 Interpretation and a second se	F 225	, , , , , , , , , , , , , , , , , , ,	ill be bed e hire ted to ult policy at becal te the attential urred on the edure frector.		
	dining room and NA "You have to eat, the so there is no reason was observed by Na pinching them toge and pushed a spoostated, "Now eat!" licensed practical na reported it to RN-B bottom of the Problem 'Above issue was result and the second of the RN of the second of the RN of the second of the RN of the R	A-D was overheard telling R58, here is nothing in your mouth on why you won't eat!" NA-D A-I grabbing R58's cheeks, ther so her mouth would open, on through R58's lips, and NA-I reported the incident to lurse (LPN)-B, who then are the documentation on the em Resolution form indicated, eviewed with [NA-D] on ease manager. [NA-D] stopped [11/14, to apologize for the last no further investigation of		completed on 12/18/14.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245465	B. WING		<del></del>	11/2	24/2014
	PROVIDER OR SUPPLIER	ме		4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	to the state agency During interview on stated she rememb R58 and NA-D. RN apologized and rec treat R58 the ways was nothing further stated she had no fincident, and it was administrator or stanot believe there withe resident did not R58 had no ongoin During interview on stated when she spincident with R58, N wrong, and NA-D sagain. DON stated re-education or cor being monitored to other residents, the of the incident, and state agency or adritis was abuse or n was not harmed, ar were not acceptable R44's annual MDS resident had diagnod disease, had mode required assistance daily living (ADL's), meals.  The facility provided was kept in the DO 11/3/14, NA-D broughis wheelchair and opened for breakfa	o R58, and it was not reported or administrator. 11/19/14, at 1:30 p.m. RN-B pered the incident between N-B stated NA-D had ognized she was wrong to the did, so the facility felt there at they needed to do. RN-B further investigation of the not reported to the not reported to the as any abuse that took place, experience any injury, and g effects from the incident. 11/19/14, at 2:36 p.m. DON poke to NA-D about the NA-D knew how she acted was tated it would not happen NA-D did not receive rective action, NA-D was not observe her interaction with the was no further investigation it was not reported to the ministrator. DON did not feel mistreatment because R58 and NA-D knew her actions	Fí	225			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245465	B. WING		11.	/24/2014
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 225	should be open berwanted to eat. NA-front of R44, "in a control of R44, and a control of R44, and a contained no further incident with NA-D. During interview on stated NA-D was verous and a meeting. National of the DON. On 11 had a meeting. RN by DON her attitudenceded to improve her ability to effective co-workers. RN-C of training or monitoring remember if NA-D about being disrespectful to the DON. On 11 had a meeting. RN by DON her attitudenceded to improve her ability to effective co-workers. RN-C of training or monitoring remember if NA-D about being disrespresidents. During interview on DON stated NA-D of 11/3/14, were wron DON stated NA-D of corrective action, we residents to ensure there was no further incident been report administrator. DON was reportable been negative effects frow had prior accusation the facility did not for further resident about the sident about the sident about the sident about the facility did not for further resident about the sident and sident about the sident and sident about the sident and sident about the si	cause R44 was hungry and D stated loudly to RN-C in disrespectful manner," then, R44] up when he lays down!" ig in the hallway in his ked away, and RN-C assisted. The untitled document er investigation regarding this a 11/19/14, at 2:24 p.m. RN-C ery disrespectful in front of e in the hallway by the dining RN-C stated after NA-D was in front of R44 she reported it -3-14, NA-D, RN-C, and DON I-C stated NA-D was instructed erowards her supervisors, and she needed to work on vely communicate with her was not aware of any further ing of NA-D, and did not was spoke to specifically pectful in front of R44 or other in 11/19/14, at 2:36 p.m. the had admitted her actions on g and would not happen again. In did not receive re-education or was not being monitored with the appropriate interactions, and er investigation, nor had the red to the state agency or N stated she did not feel this ause R44 did not have any in this incident. Although NA-D was of resident mistreatment, collow up or monitor to prevent	F 2	25		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245465	B. WING		11	/24/2014
	PROVIDER OR SUPPLIER	ЛЕ		STREET ADDRESS, CITY, STATE, ZIP ( 410 WEST MAIN STREET OSAKIS, MN 56360	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 225	written by RN-C regand resident mistre "What I felt as dem meal, stating rudely herself, even thoug more assistance to follow up with NA-D being rude to the re providing necessary interviews with staff who the resident was The incident was no or administrator, an investigation.  R47's Admission Re diagnoses of Alzhei incontinence. R47' 8/18/14, identified F impairment, was ince bladder, required ex staff for bed mobilit on staff for toileting During interview on stated while visiting she stepped out of while two nursing a cares for R47. FM- went into R47's roo stated she pulled be witnessed an unide her side, and was le elbow, which she fe FM-A stated this ma reported the incider right away. FM-A s anything about the	garding concerns with NA-D atment, indicated NA-D was, eaning to a resident at noon that a resident could feed he this resident does need feed herself." There was no regarding RN-C concerns of esident or possible neglect of y care. During multiple is, no one was able to recall as NA-D had been rude to be reported to the state agency and there was no further.  Becord dated 11/11/14, included mer's disease and urinary sequarterly MDS dated and actensive assistance of two y, and was totally dependent and personal hygiene.  11/18/14, at 11:19 a.m. FM-A R47 about five months ago, R47's room into the hallway sesistants provided personal A heard R47 moaning, and m to check on her. FM-A ack the privacy curtain, and entified NA holding R47 onto be aning onto R47 with her each to social services (SS)-A tated she had not heard incident from the facility, and did up with her regarding her	F 2	225		

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245465	B. WING			11/2	24/2014
	PROVIDER OR SUPPLIER	<b>NE</b>		STREET ADDRESS, CITY, STATE, 2 410 WEST MAIN STREET OSAKIS, MN 56360	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 225	verified FM-A had rea NA pressing down while a NA was hold personal cares. SS much about the inci involved more in the the DON would hav regarding the incide "Some of the things documented, and s"Ouring interview on stated she had never between R47 and a causing her pain, and During follow up into a.m. SS-A stated she reported the incider RN-A because DON RN-A was in charge talked to the two stated to the two stated to the two stated to the two stated the incident because resident." SS-A stated the incident because resident. "SS-A stated the incident was no she did not report the administrator, and copolicy that she need the administrator if SS-A could not recaused of being reaccused of being reaccused."	11/19/14, at 7:44 a.m. SS-A eported an incident involving a with her elbow into R47, ding R47 on her side during A stated she did not know ident, because the DON was e investigation. SS-A stated e any documentation ent, however, SS-A stated, a reported [by family] are ome are not."  11/19/14, at 8:48 a.m. DON er heard about the incident staff member leaning into her had no idea what occurred. The enview on 11/19/14, at 8:52 he now recalled she had at with R47 and the NA to N was gone that day, and e. SS-A stated she and RN-A aff members involved in a they were being roughIt gThere wasn't a lot to itIt reportable." SS-A stated there ion or investigation regarding e, "There was no injury to the ed, "No form was filled out. ot reportable." SS-A stated	F 2	225			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245465	B. WING			11/	24/2014		
	PROVIDER OR SUPPLIER	ЛЕ		410 WES	ADDRESS, CITY, STATE, ZIP CODE ST MAIN STREET S, MN 56360	,	- 11 - 12 - 1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETION DATE		
F 225	because it was not mistreatment to R4 the state agency or During interview on stated when a compshould review the ir reportablewhoeve up with the family reportIf you report four or five times a want to talk to the fathere is a grievance a concern the nurse DON verified there regarding the report. The DON stated the after a complaint by reaction to that care required monitoring mistreatment of resulting interview on administrator was a understanding the policy says the immediately. I don't injury" The admir looked at the grieve not experience any level of a reportable stated when they have the facility felt becawomen, she was go with cares, and he misunderstanding.	determined there was any 7. This was not reported to administrator.  11/19/14, at 9:00 a.m. DON plaint is received, the facility neident, "To see if it's er receives the concern follows You don't want to over to everything, you could report week." DON stated she would amily, resident, and staff first if the or concerns, and if there was the would do focus charting. Was no documentation the grievance involving R47. The facility protects a resident of the was regiver." DON verified no staff in the last 7 months related to	F 2	25					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
		245465	B. WING			11/24/2014
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STAT 410 WEST MAIN STREET OSAKIS, MN 56360	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED		
F 225	diagnoses of deme chronic kidney dise dated 10/9/14, iden cognitive impairme assistance with all and offer R12's care plan date offer R12 toileting enight, and PRN (as During interview on FM-B stated, "Som residents." FM-B stated, "Som residents." FM-B stated, and som wants to go to the residentia, and som wants to go to the residential to the bathroom, and toileting R12. FM-E concerns of staff no when requested, as staff members to R accility Grievance 11/12/14, indicated concerns regarding including staff being reminding her of the Documentation of F Reminded staff to changes; spoke with The grievance/com DON and registere no further investigated regarding staff treated by the pad overheard they had overheard they	ntia, depressive disorder, and ase. R12's quarterly MDS stiffed R12 had severe nt, and required extensive staff ADL's.  Ited 10/20/14, directed staff to every two hours, with rounds at needed) per resident request.  I 11/18/14, at 3:41 p.m. R12's e of the staff are rude to the tated R12 had the start of letimes she calls out and restroom, but staff will not take n and tell her she was just in the staff walk away without a stated she reported her of providing toileting for R12 is well as the concerns of rude in N-D.  //Complaint form dated FM-B had expressed is staff treatment of R12, grimpatient with R12 when e last toileting activity. The facility Follow-up indicated, alert nurse of behavior the staff; passed on in report" Inplaint form was signed by dinurse RN-D, and there was tion of FM-B's complaints	F 2	225		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	` '	E SURVEY PLETED
		245465	B. WING			11/2	24/2014
	PROVIDER OR SUPPLIER	ИE		4	STREET ADDRESS, CITY, STATE, ZIP CODE 110 WEST MAIN STREET DSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 225	be quiet!" The visit anyone at the facilith had made her uncowere very rude.  During interview on stated the reported mistreatment involved documented on the 11/12/14, had not be administrator or the investigation of the any staff were interregarding toileting for resident.  During interview on stated if the facility mistreatment, it wo allegation to determ required reporting, RN-B stated the fact which were mainly tears, grievance for for family complainty Problem/ Resolution if there were any constated she had not reports to the state last 7 months, and staff mistreatment to asked specifically a R52, R58, R12, R4 was aware of those injury and those we "Misunderstandings which would required."	or stated she had not told by about this, but stated this omfortable as she felt the staff of 11/21/14, at 10:07 a.m. DON incident/ grievance of staff ring R12, which was a grievance form dated een reported to the	F 2	25			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(3	(X3) DATE SURVEY COMPLETED	
		245465	B. WING			11/24/20 <sup>-</sup>	14
	PROVIDER OR SUPPLIER	<b>ЛЕ</b>		STREET ADDRESS, CITY, STATE 410 WEST MAIN STREET OSAKIS, MN 56360	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD B O THE APPROPRI	E COMP	(5) LETION ATE
F 225	staff and resident in staff and get their s conclusion. RN-B s documented because conflict or a misunor.  During a follow up in a.m., SS-A stated to have a lot of grieval grievance form if a kind. SS-A stated in would talk to the act to the staff member the investigation the suspended if the fall "done something to the residents are prinvestigation by, "Woomfort with that permistreatment]." SS injured, the staff member the facility immedian. During follow up into a.m. DON stated an involved verbal or punknown origin, we agency. DON stated filled out by the number staff will usually verconcerns. DON stated the residents and talk to reportable, and if the DON stated the resinvestigation of alle "Watching to see if behavior" The DO	ide of the story, and come to a stated every accusation isn't se usually it is a personality lerstanding.  Interview on 11/19/14, at 7:44 ypically the facility doesn't nees, but staff can fill out the family had a concern of any if there was a grievance she liministrator and DON and talk involved. SS-A stated if after e staff member would be cility determined they had the resident." SS-A stated of the resident's level of erson [staff accused of stated if the resident was ember would be removed from	F 2	225			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245465	B. WING			11/2	24/2014
	PROVIDER OR SUPPLIER	ME		4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	monitor for behaviorallegations of staff stated the facility of allegations of staff documented, and stated the incident. Do no current system being reported to the administrator, and was there a system staff involved in rest to determine if any stated staff were not form to document of mistreatment, and including incident reproblem/ resolution these forms were known workers office, son some were in a file DON verified the faresident mistreatm	or changes related to mistreatment. The DON id not feel everything related to mistreatment needed to be some things could be checking with a staff member DN acknowledged there was to ensure all allegations were ne state agency and thoroughly investigated, nor in place to track and trend sident mistreatment allegations staff had a pattern. DON of trained to use a specific concerns of resident the facility had multiple forms eports, grievance forms, and in forms. DON stated some of the time and the social ne were in employee files, and cabinet in her office. The acility had no system to track the tor to ensure all allegations the twere reported to the	F 2	225			
	a.m. administrator involved in the investigate to the investigate to the immediately, and residue it, investigate to the immediately, and residue in the immediately.	terview on 11/19/14, at 12:10 stated he felt like he was estigation process at the facility. Stated he would expect if there resident mistreatment, the sten to the complaint, evaluate extent warranted eport to him, "Accordingly."					
	the DON about res stated, "We comm same parking lot so	ident incidents daily and nunicate daily; we park in the owe see each other at least					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245465	B. WING		11	/24/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 410 WEST MAIN STREET OSAKIS, MN 56360	•	-
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 225	believed the facilit investigation, reports however, not all a "Result in injury." he was aware rescommunication will desired by the resstaff are aware the administrator immeresident mistreatmen, if it rises to the report it [to the staverified no reports agency in past 4 mbeen a total of 3 months, none of wistreatment to restated they had a management feels well, and they have their staff would must be agency regastaff mistreatment R12. The investigations sub R58, R44, R47 and incomplete and diany other staff members follow up interview if the staff members followed in the staff	age 30  y understood the process of orting, and resident protection, legations of mistreatment, The administrator also stated idents have felt that staffs the them have been, "Less then ident." The administrator stated in each to report to the ediately any allegations of ment. He stated, "If it gets to elevel of mistreatment, we ste agency]." The administrator had been filed with the state months, and there had only eports made in the last 8 which had to do with staff esidents. The administrator very small facility, so a like they know their staff very eno reason to believe any of distreat any of the residents.  acility submitted reports to the reding the above allegations of the for R52, R58, R44, R47 and eations were submitted to the 1/21/14. Review of the mitted on 11/21/14, for R52, d R12, were found to be do not include interviews with earding resident mistreatment by a involved, did not include any was with family, nor did it indicate residents any prior accusations of the control of the state of t	F 2	225		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI JER/CLIA

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD		(X3) DATE SURVEY COMPLETED			
		245465	B. WING			11/:	24/2014
	PROVIDER OR SUPPLIER	ИЕ		41	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET SAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	R12. DON verified complete and lacked 11/21/14, the facility investigation and strinvestigation reports R58, R44, R47 and The IJ that began or removed on 11/24/1 facility completed the All staff were trained prevention policy, winstruction to staff or neglect.  All prior incidents in and R12 were report thouroughly investig thouroughly investig the administrator and checklist on compute report is made to the administrator and staff or report all allegative administrator and	the investigations were not at the above information. On a completed further ubmitted amended is to the state agency for R52, R12.  In 11/19/14, at 4:19 p.m., was 14, at 1:07 p.m., when the ne following interventions:  If on the facility abuse which included specific on recognizing abuse and avolving R52, R58, R44, R47 and to the state agency and gated.  In packet was implemented and state agency, as well as obleting an investigation after to the administrator and SA. able to all staff.  If ore educated on responsibility ons of abuse to the tate agency, and begin a	F 2	225			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245465	B. WING		1.	1/24/2014
	PROVIDER OR SUPPLIER	ЛЕ		STREET ADDRESS, CITY, STATE, Z 410 WEST MAIN STREET OSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 225	Continued From particles of the facility implement grievances.  Any grievances or in reviewed by the DC On 11/19/14, the accommodate of the memo sent to all state employee accused/mistreatment invest suspended from worthe investigation.  On 11/24/14, from a direct staff were interesponsibility for ide potential mistreatment protection, investigate defined in the facility Plan.  The IJ was removed remained at a lower staff was removed the remained at a lower rema	,	F 2	DEFICIENC		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		DATE SURVEY COMPLETED
		245465	B. WING		11/24/2014
	PROVIDER OR SUPPLIER	ΛE	4	STREET ADDRESS, CITY, STATE, ZIP CODE 110 WEST MAIN STREET DSAKIS, MN 56360	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From pa	ge 33	F 225		
F 226 SS=F	The facility must de policies and proced mistreatment, negle	ETC POLICIES  velop and implement written	F 226		12/18/14
	by: Based on interview facility failed to ensipolicy and procedure residents (R52, R58 made allegations of mistreatment, and to the state agency (S did not complete a addition, the facility the facility would enfree from abuse who place of an allegation. This had the potent currently residing in Findings include: The facility policy tit and Procedure/Previndicated the follow required for non-the	AT is not met as evidenced and document review, the cure the abuse prevention re was implemented for 5 of 8 as, R44, R47 and R12) who is staff abuse, neglect, and/or he facility failed to report to A), and/or administrator, and thorough investigation. In policy failed to address how usure a resident would be kept en an investigation was taking on of resident mistreatment, it is affect all 36 residents the facility.  Iteled Vulnerable Adult Policy vention Plan dated 4/17/14, ing: "Incident reports are erapeutic physical contact lent and resident/ resident		Vulnerable adult reports were filed to the state agency on residents #47 and #12 11/19/14 and reports filed on residents #52, 58, and 44 on 11/21/14. All reports were thoroughly investigated and the results of those investigations were file to the state agency within the regulation requirements of the 5 working days. Internal facility investigation led to the termination of 2 employees. One employee was suspended pending furt training on resident transfers and one employee required additional demential education. The two employees that received further education were allowere turn to work after the education had been completed. All above residents affected had care plans reviewed. No	on d n her

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		245465	B. WING			11/24/2014	
	PROVIDER OR SUPPLIER	ИE		4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	patterns, occurrence need for reporting. case manager will rather and other staff as no investigation. Internand staff are solicite understanding of the investigation reveal occurred, the staff rather area or must further notice All sampler area or must further notice All sampler and the form, notified of every repromplete the form, neglect of a VA I given to [SA] immerincident is received believe a resident is resident has sustain not reasonable exp (when on duty) or, if the DON, SS, or suffor the resident will report to the SA]"  Findings include:  R52's Face Sheet of diagnoses including scoliosis, and pain R52's quarterly Min	anager will look for possible res, or trends that may indicate After investigation, the DON/ make a reporting decision department supervisor, DON leeded are involved in the views with resident, family, red to gain the best le event. When an s abuse/ neglect has member must be separated The nurse in charge will lember can be reassigned to st leave the building until staff need to report suspected rulnerable adult (VA) to the lon duty or social services (SS). lity Administrator must be loort immediately. Staff should Report of Suspected abuse/ nitial incident report must be diately after knowledge of the where there is reason to s or has been maltreated or a ned a physical injury which is lained The administrator n place of the administrator, pervising nurse responsible be the person submitting [the	F 2	226	adjustments were required. Mood/behavior focus charting was initiated and completed on all reside #52, 58, 44, 47 and 12 to monitor for changes in psychosocial wellbeing. concerns or effects from the filed rewere noted.  Interviews conducted with all nursing on 11/19/14 and interviews conducted with all residents in the facility on 11 to identify other potential cases of reglect or mistreatment. During resinterviews, one incident was reported agency. The incident was then investigated per Vulnerable Adult Pand procedures. Staff member involved as suspended and received additional training on transfers prior to her reting work schedule. Safety Risk assessing were completed on all residents and plan changes were adjusted.  Zero Tolerance statement initiated affacility administrator. Vulnerable Add Policy and Procedure was reviewed revised to include the protection of residents during an alleged act of abuse/neglect. Changes include immediate removal and/or suspens alleged perpetrator. All licensed state received training and direction on his submit an alleged report of abuse to state agency. An in-service training trained consultant was conducted from Vulnerable Adult and Abuse. This education included reviewing the hacopy of the updated Vulnerable Adult and consultant was conducted from Vulnerable Adult and Abuse. This education included reviewing the hacopy of the updated Vulnerable Adult and	or any No eports  ag staff ied 1/20/14 esident ident i	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING		11/2	24/2014	
	PROVIDER OR SUPPLIER	ме	,	STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360			
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F 226	bearing assistance  During interview on stated a few weeks (NA) grabbed her of from the wheelchai she hit her hip on the stated she, "Hollere pain," because the stated she reported nurse (RN) case me facility had spoke to the stated she reported nurse (RN) case me facility had spoke to the stated she reported nurse (RN) case me facility had spoke to the stated she thought had spoke to treatment from a stand stated she thought had stated she thought had stated she thought had stated she would, "Shy aw provide cares to he caused during the litransfer.  During interview on stated she was awardle NA transferring spoken with both Resincident. The DON made to the SA regithere was no docur determining what he facility policy.  During interview on service (SS)-A and	ge 35 quired extensive weight from two staff for transfers.  11/17/14, at 3:34 p.m. R52 ago, a male nursing assistant on the arm during a transfer r to the bed, and was so rough ne nightstand table. R52 ed and screamed from the transfer was so rough. R52 I the incident to the registered anager, but no one from the o her about the incident.  rview on 11/8/14, at 2:53 p.m. ner concerns of rough aff member during a transfer, ught the NA was too rough er and didn't understand what bain. R52 stated the NA had to her since this incident, but vay," from that NA if he were to r again due to the pain he ast time he assisted her to  11/18/14, at 3:35 p.m. DON are of R52's allegation of a g her roughly, and she had 52 and the NA about the confirmed no report had been larding the allegation, and mented investigation ad happened according to the  11/18/14, at 6:29 p.m. social the DON were interviewed mplaint of rough treatment by	F 226	Abuse and Prevention Plan, an discussion on different types of including examples of physical, and emotional abuse. The staff educated on the new disciplinar procedures during reports of all abuse. The new Abuse Protocol were also reviewed and the conthem were discussed at the insedirector of nursing conducted 2 meetings to review Vulnerable And procedures. Policy and Procedures. Policy and Procedures. Policy and Procedures and procedures and procedures and procedures and vulnerable Active and review of incidents and Vulnerable Active and review of incidents and Vulnerable Active and review of incidents and vulnerable Active and and review of incidents and vulnerable Active and active and procedures will be reviewed quality basis the Morning Standup Meeting a with the IDT team. All unresolved grievances will be reviewed quality and the QA team for further review and direction for resolution. An incidents are viewed during Morning Standuthen the incident will be placed or record. The log will be reviewed during IDT and quarterly with Quassure that all incidents are fully investigated and complete. A negrievance form was developed and onto place. Staff were educated director of nursing on the locatic proper use of the new facility griforms.  Staff education of Vulnerable Active and procedures and procedures are fully investigated and complete. A negrievance form was developed and put into place. Staff were educated director of nursing on the locatic proper use of the new facility griforms.	abuse verbal, were also y eged folders tents of ervice. The staff adult policy cedures of and unication nerable incidents during and weekly ed rterly with and ent log ee by the swill be up and on the log weekly A to ew and put by the on and evance		

STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
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F 226	the NA. SS-A stated and reported R52 v treatment by staff of she had talked to the incident, howeved documented the incident, the incident, and to be made to the stated there was not investigation or interactused of rough the training or monitorismistreatment did not facility policy directs should be reported administrator and scompleted for R52.  During interview on stated she was awa month ago regarding a NA. RN-B stated completed with the R52 roughly, as we documented any of reported R52's accompleted R52's	d R52's family had called her was upset about rough luring a transfer. SS-A stated he NA and charge nurse about yer, SS-A stated she had not westigation regarding the views, and she did not report ency or administrator. SS-A ey had spoken with R52 about e resident did not experience didn't believe the allegation of potential abuse, neglect, or determined no report needed state agency. SS-A and DON to documentation regarding any erviews, and the NA who was reatment of R52 had no further and to ensure further resident of occur. DON verified the end any allegations of abuse immediately to the tate agency, and this was not	F 2	226	and Procedure will continue throug QAPI. During resident council on 12/18/14, a review of Vulnerable Ac Policy and Procedure and grievanc procedure took place. All IDT week minutes will be reviewed quarterly QA team to review incidents and pot trends of abuse. Upon this review s revisions and/or staff education will implemented indicated via proscrib written action plan. New employee packets and education were update include revisions to Vulnerable adu and procedures. Quarterly resident interviews will be conducted by soc services or her delegate to facilitate identification of any actual or potent issues. Quarterly QA meeting occu 12/16/14. New changes related to the Vulnerable Adult Policy and Proced were reviewed with the medical direct The Director of Social Services will responsible for monitoring that all allegations of abuse/neglect or misappropriation are reported and investigated according to facility poon The Administrator will be responsible facility compliance.  Corrective action for this tag has be completed on 12/18/14.	dult e ly log with the otential system be ed hire ed to lt policy ial e the tial rred on he ure ector. be licy. le for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245465	B. WING		11	/24/2014
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		
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F 226	administrator state would be handled a would work with the and would only be mistreatment, for e from the rough transure if he was me the rough transfer he knew the NA ac with R52, and he dintentionally mistre administrator verificating to the state agency however, this was R58's quarterly MDR58 had severely i required assistance eating.  Review of a facility dated 8/7/14, indicating room and N. "You have to eat, the so there is no reas was observed by N pinching them toge and pushed a spoostated, "Now eat!" licensed practical results and would be a spoostated.	n 11/19/14, at 12:13 p.m., the d rough transfers of a resident as a complaint and facility staff e family to resolve the concern, reported if it rose to the level of example, if an injury resulted asfer. The administrator was rade aware of the allegation of with R52, however, he stated cused of the rough transfer id not believe the NA would at a resident. The ed the facility policy instructed alleged resident mistreatment of and then investigate,	F 22			
	"Above issue was in 8/8/14, by the RN of in DON office on 8/2 incident." There we	lem Resolution form indicated, reviewed with [NA-D] on case manager. [NA-D] stopped /11/14, to apologize for the as no further investigation of DR58, and it was not reported				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CO 410 WEST MAIN STREET OSAKIS, MN 56360		,_,,
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F 226	to the state agency During interview or stated she remember R58 and NA-D. R1 apologized and receive treat R58 the ways was nothing further stated she had no incident, and it was administrator or stated when she sprincident. During interview or stated when she sprincident with R58, I wrong, and NA-D sagain. DON stated re-education or corbeing monitored to other residents, the of the incident, and state agency accordid not feel this was because R58 was her actions were not R44's annual MDS resident had diagned disease, had mode required assistance daily living (ADL's), meals.  The facility provide was kept in the DC incident involving Findicated on 11/3/1 dining room in his was not opened for	age 38 If according to the facility policy. In 11/19/14, at 1:30 p.m. RN-B overed the incident between N-B stated NA-D had cognized she was wrong to she did, so the facility felt there in they needed to do. RN-B further investigation of the state agency because they did has any abuse that took place agoing effects from the NA-D knew how she acted was stated it would not happen if NA-D did not receive rective action, NA-D was not observe her interaction with ere was no further investigation if it was not reported to the reding to the facility policy. DON is abuse or mistreatment not harmed, and NA-D knew to acceptable and apologized. It was not reported to the obsessincluding Alzheimer's erately impaired cognition, and are of one staff with activities of and set up assistance with the obsessince of the obsession of the obsessince of the obsession of	F 22	6		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245465	B. WING			11/2	24/2014
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F 226	hungry and wanted RN-C in front of R4 then, "You can get down!" NA-D left F wheelchair and wal R44 to get a snack. contained no furthe incident with NA-D. During interview on stated NA-D was vereased NA-D was vereased NA-D was vereased NA-D was vereased to the DON. On 11 had a meeting. RN by DON her attitude needed to improve, her ability to effective co-workers. RN-C vertaining or monitoring the modern of the NA-D was vereased NA-D had as were wrong and wo stated NA-D did not corrective action, we residents to ensure there was no further incident been report according to the fact did not feel this was not have any negat Although NA-D had mistreatment, the famonitor to prevent for occurring.	be open because R44 was to eat. NA-D stated loudly to 4, "in a disrespectful manner," him [R44] up when he lays R44 sitting in the hallway in his ked away, and RN-C assisted The untitled document r investigation regarding this 11/19/14, at 2:24 p.m. RN-C ery disrespectful in front of e in the hallway by the dining RN-C stated after NA-D was in front of R44 she reported it -3-14, NA-D, RN-C, and DON -C stated NA-D was instructed e towards her supervisors and she needed to work on vely communicate with her was not aware of any further ng of NA-D, and did not was spoke to specifically bectful in front of R44. 11/19/14, at 2:36 p.m. DON dimitted her actions on 11/3/14, and not happen again. DON at receive re-education or as not being monitored with appropriate interactions, and r investigation, nor had the ted to the state agency cility policy. DON stated she is reportable because R44 did investigations of resident accility did not follow up or further resident abuse from the document dated 11/3/14, and document dated 11/3/14,	F 2	226			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING	·	1.	1/24/2014	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CO 410 WEST MAIN STREET OSAKIS, MN 56360	•	1/24/2014	
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F 226	and resident mist "What I felt as de meal, stating rude herself, even thou more assistance follow up with NA being rude to the interviews with stawho the resident R47's Admission diagnoses of Alzhincontinence. R4 8/18/14, identified impairment, was bladder, required staff for bed mobi on staff for toiletin During interview of stated while visiting she stepped out of while two nursing cares for R47. Flywent into R47's rostated she pulled witnessed an unit her side, and was elbow, which she FM-A stated this in reported the incideright away. FM-A anything about the no one had follow.  During interview of weified FM-A had a NA pressing downile a NA was here.	reatment, indicated NA-D was, meaning to a resident at noon ely that a resident could feed uph this resident does need to feed herself." There was no-D regarding RN-C concerns of resident. During multiple aff, no one was able to recall was NA-D had been rude to. Record dated 11/11/14, included eimer's disease and urinary 7's quarterly MDS dated 1 R47 had severe cognitive incontinent of bowel and extensive assistance of two lity, and was totally dependent up and personal hygiene. In 11/18/14, at 11:19 a.m. FM-A in R47 about five months ago, of R47's room into the hallway assistants provided personal M-A heard R47 moaning, and dentified NA holding R47 onto a leaning onto R47 with her felt was causing R47, "Pain." made her upset, and she ent to social services (SS)-A estated she had not heard e incident from the facility, and	F2	226			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245465	B. WING			11/24/2014	
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F 226	involved more in the the DON would have regarding the incider. "Some of the things documented, and some of the two stated she had never between R47 and a causing her pain, a cause DON was in charge. SS-A stated some one-time thingThe appear to be report no documentation of incident because, "resident." SS-A stated that they were some-time thingThe appear to be report no documentation of incident because, "resident." SS-A stated some of the administrator, and opolicy that she need the administrator if SS-A could not recaused of being rounding would be in because it was not mistreatment to R4 followed up with FM staff maltreatment,	ident, because the DON was a investigation. SS-A stated re any documentation ent, however, SS-A stated, a reported [by family] are ome are not."  11/19/14, at 8:48 a.m., DON re heard about the incident a staff member leaning into her and had no idea what occurred.  rview on 11/19/14, at 8:52 he now recalled she had not with R47 and NA to RN-A gone that day, and RN-A was ated she and RN-A talked to res involved who were so that day, and, "They did not being roughIt was a rere wasn't a lot to itIt didn't able." SS-A stated there was no injury to the red, "No form was filled out. There was no injury to the red, "No form was filled out. The incident to the did not know if it was in their ded to report the incident to it was not considered abuse. The employees were ough with R47, and stated the employees personal file determined there was any so she was any	F 2	226			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
245465			B. WING			11/24/2014	
	PROVIDER OR SUPPLIER	ЛE		4	STREET ADDRESS, CITY, STATE, ZIP CODE 110 WEST MAIN STREET DSAKIS, MN 56360		
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F 226	stated when a complete should review the irreportablewhoeved up with the family reportIf you report four or five times a want to talk to the fathere is a grievance a concern the nurse DON verified there regarding the report and she did not believed with regarding the after a complaint by reaction to that care required monitoring mistreatment of resulting interview on administrator was a ware of the mistre R47's family memb "The policy says the immediately. I don't injury" The adminitured at the grieve and experience any level of a reportable stated when they have the facility felt becawomen, she was gowith cares, and he imisunderstanding, acknowledged the facility felt becawonledged the facility felt becawonledge	11/19/14, at 9:00 a.m. DON plaint is received, the facility neident, "To see if it's er receives the concern follows You don't want to over the everything, you could report week." DON stated she would amily, resident, and staff first if the or concerns, and if there was the would do focus charting. Was no documentation the grievance involving R47, lieve FM-A was followed up allegation of abuse to R47. The facility protects a resident of the protects are sident of the last 7 months related to eidents.  11/19/14, at 11:42 a.m., the mable to clearly state if he was atment allegation made by the resident of the last 1 need to be made aware think it was a report of the instrator stated the facility ance, and determined R47 did harm, so it didn't rise to the elincident. Administrator and spoke about this incident, use R47 was a heavier ong to require "extra support" obelieved it was just a	F 2	26			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING COMPL	(X3) DATE SURVEY COMPLETED 11/24/2014	
245465 B. WING 11/24		
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME  STREET ADDRESS, CITY, STATE, ZIP CODE  410 WEST MAIN STREET  OSAKIS, MN 56360		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
R12's Admission Record dated 1/18/08, included diagnoses of dementia, depressive disorder, and chronic kidney disease. R12's quarterly MDS dated 10/9/14, identified R12 had severe cognitive impairment, and required extensive staff assistance with all ADL's.  R12's care plan dated 10/20/14, directed staff to offer R12 toileting every two hours, with rounds at night, and PRN (as needed) per resident request.  During interview on 11/18/14, at 3:41 p.m. R12's FM-B stated, "Some of the staff are rude to the residents." FM-B stated R12 had the start of dementia, and sometimes she calls out and wants to go to the restroom, but staff will not take her to the bathroom and tell her she was just in the bathroom and the staff walk away. FM-B stated she reported her concerns of staff not providing toileting for R12 when requested, as well as the concerns of rude staff members to RN-D.  A facility Grievance/Complaint form dated 11/12/14, indicated FM-B had expressed concerns regarding staff treatment of R12, including staff being impatient with R12 when reminding her of the last toileting activity. The Documentation of Facility Follow-up indicated, "Reminded staff to alert nurse of behavior changes; spoke with staff; passed on in report"  The grievance/complaint form was signed by DON and registered nurse RN-D, and there was no further investigation of FM-B's complaints regarding staff treatment of R12.  During interview on 11/18/14, at 11:45 a.m. an unidentified visitor at the facility stated on 11/7/14,		

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		245465	B. WING		11	11/24/2014	
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F 226	they had overheard to use the restroom you that when I was be quiet!" The visit anyone at the facilith had made her uncowere very rude.  During interview on stated the reported mistreatment involved documented on the 11/12/14, had not be administrator or the policy. DON had not and could not verify or re-educated regard During interview on stated if the facility mistreatment, it wo allegation to determinvestigation, if it rewould be documented incident reports falls or bruises/ skir which could be filled and also had forms forms, which could concerns involving not been involved in state agency in the aware accusations residents. When Rabout the incidents	R12 ask NA-J for assistance in NA-J stated to R12, "I told is done, I would help you. Now or stated she had not told by about this, but stated this imfortable as she felt the staff of the	F 2	,			
	considered more, "	was no injury and those were Misunderstandings" then t. RN-B stated if she is made					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
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F 226	aware of any conceinteraction, she will side of the story, ar RN-B stated every because usually it i misunderstanding. the facility policy insadministrator and Sabuse, and then invhad been no concerequired notification.  During a follow up it a.m., SS-A stated thave a lot of grieval mistreatment to resignievance form if a kind. SS-A stated it would talk to the act to the staff member the investigation the suspended if the fall done something to the residents are prinvestigation by, "Woomfort with that permistreatment]." SS injured, the staff methe facility immediately forms are filled out doesn't usually received the staff of the staf	erns with staff and resident talk to the staff and get their and come to a conclusion. accusation isn't documented is a personality conflict or a RN-B stated she was aware structed staff to notify the stated there is a mediately of any resident restigate. RN-B stated there is with abuse, so nothing in to the SA or administrator.  Interview on 11/19/14, at 7:44 repically the facility doesn't inces/ allegations of staff idents, but staff can fill out the family had a concern of any if there was a grievance she iministrator and DON and talk involved. SS-A stated if after the staff member would be collity determined they had the resident." SS-A stated of otected during a facility ratching the resident's level of the staff accused of staff accused of staff accused of staff accused from sember would be removed from	F 2	226				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING			11/:	24/2014
	NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME			41	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET PSAKIS, MN 56360		
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F 226	usually get togeth incident is reportatinjury's. DON stated during an investig by, "Watching to see behavior" The residents in the pate to monitor for behallegations of staff stated the facility allegations of staff documented and/administrator, and determined just be on the incident. In the incident of the incide	er and talk to determine if the able, and if the resident had any ted the resident is protected ation of alleged mistreatment see if there is any changes in DON stated there were no ast 8 months they had needed avior changes related to f mistreatment. The DON did not feel everything related to f mistreatment needed to be or reported to the SA and d some things could be y checking with a staff member DON acknowledged there was a to ensure all allegations were d investigated, nor was there a contrack and trend staff involved atment allegations to determine the pattern. DON stated staff were a certain form to document ent mistreatment, and the facility is including incident reports, and problem/ resolution forms. The some were in a file cabinet in DN verified the facility had no esident mistreatment, and the lowing their abuse policy for estigating allegations of resident interview on 11/19/14, at 12:10	F 2	226			
	a.m. administrato involved in the inv The administrator was a complaint of	r stated he felt like he was restigation process at the facility. stated her would expect if there of resident mistreatment, the listen to the complaint, evaluate					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING			11/2	24/2014
	PROVIDER OR SUPPLIER	ЛE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	The administrator sethe DON about resistated, "We common same parking lot so twice a day." The abelieved the facility investigation, report however, not all alle "Result in injury." The was aware reside communication with desired by the residestaff are aware the administrator immeresident mistreatment, if it rises to the report it [to the state verified no reports hagency in past 4 medical been a total of 3 remonths, none of whomistreatment to resistated they have a management feels well, and they have their staff would mistreatment administrator, and thowever, the administrator, and thowever, the administrator wistaff was following the staff was followed the staff was follo			226			12/18/14
SS=E	INDIVIDÚALITY	omote care for residents in a	1 2	_71			12/10/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 410 WEST MAIN STREET OSAKIS, MN 56360			
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F 241	enhances each re full recognition of land recognition in the land recognition is a severely cognition of land recognition in the land recognition is a severely cognition in the land recognition is a severely cognition of land recognition in the land recognition is a severely cognition of land recognition in the land recognition is a severely cognition in the land recognition in the land recognition is a severely cognition in the land recognition in the land recognition in the land recognition is a severely cognition in the land recognition in the land recognition is a severely cognition in the land recognition in the land recognition is a severely cognition in the land recognition in the land recognition is a severely cognition in the land recognition in the land recognition is a severely cognition in the land recognition in the land recognition is a severely cognition in the land recognition in the land recognition is a severely cognition in the land recognition is a severely cognition in the land recognition in the land recognition is a severely cognition in the land recognition in the land recognition is a severely cognition in the land recognition in the land recognition is a severely cognition in the land recognition in the land recognition is a severely cognition in the land recognition in the land recognition in the land recognition is a severely cognition in the land recognition in the land recognition is a severely cognition in the land recognition in the land recognition is a severely cognition in the land recognition in the land recognition in the land recognition is a severely cognition in the land recognition in the l	environment that maintains or sident's dignity and respect in his or her individuality.  ENT is not met as evidenced ation, interview, and document failed to ensure 10 of 13 uired staff assistance with 10, R14, R19, R21, R25, R40, re provided dining assistance in r.  imum Data Set (MDS) dated R1 was severely cognitively ired extensive assistance with dated 9/18/14, identified R3 nitively impaired and required ace with eating.  DS dated 9/25/14, identified R14 nitively impaired and required ace with eating.  DS dated 8/21/14, identified R14 nitively impaired and required ace with eating.  DS dated 8/7/14, identified R19 nitively impaired and required and required and required and required and required and required nitively impaired and required	F 24		14,19, 21, 25, dining and propriate per ans.  I assist in the ed to assure that e interventions eating wed, no changes lewed and th acuity and ropriate staff dents with all  leted to ensure f appropriate roviding dining in a dignified gnity Policy and I Food Service e changes to		
	R21's admission N R21 was severely	MDS dated 9/20/14, identified cognitively impaired and was on staff for eating.		team.  Audits will be conducted be manager or her delegate 8	y the dietary		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		245465	B. WING _		11/	24/2014	
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F 241	R25 was severely or required extensive R40's annual MDS was severely cognidependent on staff R46's annual MDS was severely cogniextensive assistance R58's quarterly MDR58 was severely or required extensive During observation 11/17/14, from 6:04 assistant (NA)-A was stool which had wharound two tables was reduired extensive R58 and R19 sat. In minutes feeding on wheel around to an same table or anot few minutes, and the resident to assist the rolling on the stool, R19 twice encourar refused to eat. NAmore than a few see eat. At 6:37 p.m., Noresidents from the During the same muntil 6:27 p.m., NAbetween a stool with the required to the same muntil 6:27 p.m., NAbetween a stool with the required to with the residents from the same muntil 6:27 p.m., NAbetween a stool with the required extensive the residents from the reside	os dated 10/16/14, identified cognitively impaired and assistance with eating.  dated 10/9/14, identified R40 tively impaired and was totally for eating.  dated 8/21/14, identified R46 tively impaired and required ce with eating.  S dated 10/2/14, identified cognitively impaired and assistance with eating.  of the evening meal on 4 p.m. to 6:37 p.m., nursing as observed sitting on a round eels on. NA-A wheeled where R25, R46, R40, R14, NA-A would spend a few the resident, and then would tother resident either at the her table and feed them for a nen roll away to another nem with eating. NA-A stopped stood up, and spoke with ging the resident to eat. R19 A did not sit down or spend econds encouraging R19 to JA-A started removing	F 24	quarter to assure that complimaintained by staff. The result audits will be reviewed week IDT meeting and then review QA team to evaluate the outcaudits  Corrective action for this tag completed on 12/18/14.	ults of these ly during the red with the come from		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245465	B. WING	B. WING			11/24/2014	
	PROVIDER OR SUPPLIER	ΛE		410	EET ADDRESS, CITY, STATE, ZIP CODE WEST MAIN STREET AKIS, MN 56360			
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F 241	observed telling R1 now." R1 continued NA-D replied, "I know everyone else for a you." R1 was obse a straw several diffedo so without assist During interview on medication aid (TM four staff in the dinimeal to assist apprequired assistance staff usually feed the fastest first and the TMA-A stated an he from the beginning the last person who finished eating.  During interview on registered nurse (R three to five staff as residents who required the dining room durstated which the redining room first, is she did not think se same time and ther couple of minutes we experience, and fel rushed and mealting stated should focus residents at a time, to be assisted time.	buring the meal NA-D was she was, "Going to help [R21] do to ask for bites of food and bw, we're just going to assist bit. We're not going to forget rived attempting to drink from berent times, but was unable to	F 2	241				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245465	B. WING	·····	11/24/2014	
	PROVIDER OR SUPPLIER	<b>NE</b>	4	TREET ADDRESS, CITY, STATE, ZIP CODE  10 WEST MAIN STREET  DSAKIS, MN 56360		
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F 241	recalled being press the meal on 11/17/1 observing NA-A or I dining room, but sta manner of feeding i  During interview on administrator stated using stools with wh feed multiple reside administrator stated to state of the sta	11/20/14, at 5:22 p.m. NA-G ent in the dining room during 4. NA-G did not recall NA-D wheeling around the ated it was not a dignified residents.  11/21/14, at 1:50 p.m. the did he was aware staff were neels on them and working to ents at the same time. The did it was obviously not ideal.  Iled Feeding a Resident dated sidents were to be assisted enter that maintained or ident's dignity and respect. FORTABLE & SAFE EVELS  Evide comfortable and safe Facilities initially certified 90 must maintain a of 71 - 81° F  NT is not met as evidenced ion, interview, and document ailed to maintain comfortable for 1 of 3 residents (R45) aints of cold room	F 257	F257  Maintenance director ordered and completed installation on a new thermostat in resident #45 s room 12/3/14. Temperature audit was completed following installation. Re stated saints of cold room temperature complaints of cold room temperature installation of power thermostate.	sident re	
		imum Data set (MDS) dated R45 had no cognitive		complaints of cold room temperatur since installation of new thermostat		

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F 257	stated his room was long sleeved shirt a blanket. The therm degrees.  During observation 9:00 a.m. the therm was not in his room  During observation 1:40 p.m. with main thermometer read or residents can report him, or staff can fill forms. M-A stated checks of resident latches to ensure the did not keep record recall any issues with room.  When interviewed of stated he had report cold temperature in not received any retemperatures being A undated facility portion of the comfort indicated, season and monthly thermostats will be comfort. After adjust staff will stop back was use the resident is the current temperature.	11/17/14, at 6:10 p.m. R45 stoo cold. R45 was wearing a nd was covered with a ostat in R45's room read 68 of R45's room on 11/20/14, at iometer read 66 degrees. R45 at this time.  of R45's room on 11/20/14, at iometer read 66 degrees. R45 at this time.  of R45's room on 11/20/14, at itenance (M)-A the 64 degrees. M-A stated to cold room temperatures to out maintenance request he does random temperature rooms and will check window hey are latched, however, he of the checks and could not the R45's temperature of his on 11/20/14, at 1:50 p.m. R45 sted to staff his concerns of the his room. M-A stated he had ports of R45's room	F 2	57	occurred with resident #45.  Resident interviews completed by maintenance director on 12/4/14. No concerns reported by residents in for froom temperature issues.  A policy on resident room temperation was developed on 12/4/14 and molast on 12/15/14 by the maintenance director.  The maintenance director or his dewill audit all resident rooms weekly will be ongoing. A room temp log woreated and put into use to docume these audits on resident room temperatures. Any discrepancies of grievances regarding the temperation resident rooms will be documented grievance report and reviewed with maintenance director to assure foll has been completed and that room temperatures remain within the fed requirements of 71-81 degrees F.  The corrective action for this tag work completed on 12/15/14.	acility cures dified be elegate which ras ent r ure of l on a the ow up	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 257 F 280 SS=D	The resident has the incompetent or other incapacitated under participate in plannic changes in care and A comprehensive of within 7 days after the comprehensive associated interdisciplinary teaphysician, a register for the resident, and disciplines as deter and, to the extent put the resident, the resident, the resident interdisciplinary that is a social representative.	0(k)(2) RIGHT TO NNING CARE-REVISE CP  The right, unless adjudged between the laws of the State, to large care and treatment or	F 25			12/18/14	
	by: Based on interview failed to revise the presidents (R21) with Findings include: R21's admission M 9/20/14, identified F	NT is not met as evidenced and record review, the facility plan of care for 1 of 3 in significant weight loss.  In significant weight loss.  Inimum Data Set (MDS) dated R21 was severely cognitively otally dependent on staff for		F280 R21 was re-evaluated and ass assure that appropriate interve in place and care planned app 21 was admitted to Hospice or Dietary manager reviewed all cresidents in the facility for risk for weight loss. Care plans upon	entions were ropriately. R n 12/8/14. other or potential		

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F 280	R21's care plan dar required assistance modified texture die The goal was to madirected to monitor plan did not identify weight loss.  R21's nutritional ris 9/23/14, identified is received a regular, unable to make me was totally fed by attempt to feed him  R21's documented 9/17/14 159 p 10/1/14 156.5 10/8/14 156.5 10/8/14 156.5 10/22/14 149.5 a 6% decrease from month prior 10/29/14 148.5 10.5 pounds since 11/12/14 148 p 11/19/14 146 p weight loss from 15 earlier  During interview on manager (DM)-A st would trigger a noti resident's weight distated R21 had firs 10/22/14, with a los would complete the care plan, and confired in the care plan in th	ted 11/17/14, identified R21 with eating, received a et, and was lactose intolerant. aintain weight and staff were food and fluid intake. The care of R21 had sustained any  k assessment completed R21's weight was 159 pounds, pureed texture diet, was eal/food preferences known, staff, and did not make any uself  weights included the following: ounds pounds pounds pounds pounds which was flagged as m 159 pounds less than a  pounds which was a loss of admission	F 280	accordingly to results of audits.  Policy and procedure on Resident Loss was reviewed and revised by dietary manager. Certified dietary manager will print off weight summ report weekly and review with regist dietician monthly or as needed wit significant unplanned resident weigweekly to RN case managers and weekly IDT meetings and quarterly QA meetings.  Dietary manager will conduct ongoing weekly weight audits on all resident the facility to track and address reswith weight loss. The results of the audits will be shared with the RN C managers, members of IDT and C to assure all interventions are in plappropriate. The DON or designed review weekly audit reports to assuall weight loss is care planned and appropriate interventions have been implemented. The results of these will be brought forth to the quarterly meeting to assure that all interventioner were placed and policies were followed.  The corrective action for this tag we completed on 12/18/14.	nary stered h ght loss, DON, during h sidents ese Case A team ace and e will ure that en audits y QA tions bwed.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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F 280	Review of the facilit Weight Loss dated would be considere loss if they had great one month or great three months. The gave direction to repertinent information A facility policy titled Careplan Process landicated information from all disciplines aupdated for each detrained to write care reviewed monthly, at 483.25 PROVIDE CHIGHEST WELL BITTERS WELL BITT	lated to the weight loss.  by policy titled Significant 10/12/10, indicated residents of to have significant weight later than 5% weight loss in the er than 7.5% weight loss in procedure within the policy view the care plan for n.  character Conferences and last updated on 1/20/10, on for the care plan may come land will be written and lepartment by staff members a plans. Care plans would be characterly, and as needed.  CARE/SERVICES FOR	F 28			12/19/14
	by: Based on observat review, the facility fa wheelchair position	ion, interview, and document ailed to provide proper ing for 4 of 4 residents (R1, ) reviewed for wheelchair		F309 R1, 10,47 and 50 were screened by and orders obtained for assessmer wheelchair positioning. All other residents in facility that util Broda chairs were screened and or	nt of lize	

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F 309	Findings include: R1's quarterly Minit 10/23/14, identified impairments, requit two staff with transone staff for locome. R1's care plan date a full BRODA (a typlocomotion and sea During observation was observed sittinher feet dangling a wheelchair cushion her legs.  During observation R1 was again obse down on her wheel support, and wheel her feet. R1 was cop.m. when nursing in bed. R1's feet refoot rest with no sure During interview or assistant (NA)-B are current wheelch NA was sure of the assigning wheelch wheelchair cushion because her feet d support. She furthe the chair was "not in place.	mum data set (MDS) dated the resident had no cognitive red extensive assistance of fers, and total assistance of otion on and off the unit.	F 3	obtained if positioning concented. Policy and Procedure for Reatherapy Screens was deve implemented to address serpositioning. Licensed nursing contracted therapy staff were new policy. Policy was reviewed Quarterly QA meeting. Audits will be completed by her delegate to assure that admissions, residents with schanges, and or residents to review of positioning, have the results of those audits with weekly IDT and quarter evaluate that policies have In the corrective action for this completed on 12/19/14.	esident loped and ating and og staff and re educated on ewed during the DON or all new significant hat required occurred and vill be shared rly QA team to been followed.	

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	PROVIDER OR SUPPLIER	ΛE		41	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET SAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	based on decisions team meetings by to buring interview on occupational therapthe BRODA chairs had been put in her weight and needing lacked another type would fit R1. OT wif R1's current wheer resident. OT stated lack of wheelchair emanagement as rechowever, the facility equipment was limited R10's quarterly MD resident had severe total assist of two serequired total assist locomotion in her with R10's face sheet dadiagnoses including intervertebral discs.  R10's care plan data resident was wheel and used a pressur cushion.  R10's most recent of 5/20/14, did not add positioning needs for During observation.	ints received their wheelchairs made at the interdisciplinary he licensed nurses.  11/20/14, at 2:08 p.m. the poist (OT) stated she disliked for residents. OT stated R1 current chair due to gaining a larger chair, and the facility of reclining wheelchair which as not involved in determining elchair was appropriate for the dishe reported concerns of equipment for all residents to cently as the previous week, by funding for wheelchair ted.  S dated 9/25/14, indicated the ecognitive impairment, was a staff for all transfers, and cance of one staff member for theelchair.  Ated 11/21/14, indicated the end osteoporosis.  ded 11/21/14, indicated the end by staff to all destinations, ereducing wheelchair	F3	09			

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 309	wheelchair cushion  During observation R10 was observed slouched position, with wind-thigh level.  During interview on stated residents recon decisions made meetings by the lice.  During interview on stated she had not positioning.  R50's quarterly MD resident had severe was an extensive at the second all destination.  During observation was observed in a refoot support, his feet touch the floor.  During continuous of from approximately R50 was observed wheelchair at the en R50 was moving his trying to propel hims to move as his feet	wheelchair and had a tucked beneath her legs.  on 11/20/14, at 10:39 a.m. in her wheelchair and was in a with the wheelchair seat at the 11/18/14, at 3:28 p.m. NA-D seived their wheelchairs based at the interdisciplinary team	F3	09			

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 309	was observed seated dining room. The Eupright position, and above the floor and During interview on occupational therapput in the BRODA okyphosis (a condition curvature of the spin wheelchair position stated the residents he could propel him R47's quarterly MD resident had severe required extensive adestinations with a R47's care plan datused a wheelchair from R47's OT therapy in R47's OT therapy in R47's of therapy in R47's nursing progress of space wheelchair following:  -11/6/14, at 10:42 a leaning forward in wheelchair -11/13/14, at 5:37 a wheelchair -11/15/14, at 5:49 a wheelchair -11/16/14, at 5:59 a	ed in the BRODA chair in the BRODA chair was in the BRODA chair was in the d R50's feet were dangling did not touch the floor.  11/20/14, at 2:08 p.m. the poist (OT) stated R50 had been chair due to a diagnoses of on that causes excessive me). OT stated R50's ing was, "Not very good," and a feet should touch the floor so iself.  S dated 8/7/14, indicated the excognitive impairment and staff assistance to and from wheelchair.  Med 11/21/14, indicated R47 for all mobility.  Otes dated 11/12/14, indicated and poor positioning in her tilt of the communication.  Bes notes identified the communication.	F3	309		

	TOP CORRECTION  DENTIFICATION NUMBER:  245465  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 60 During observation on 11/20/14, at 10:30 a.m., R47 was observed in her wheelchair. The wheelchair seat appeared too short, coming only about a third of the way up R47's thigh, causing R47 to slouch in her chair and slide forward.  During interview on 11/20/14, at 10:30 a.m., family member (FM)-A stated R47 had slid out of her wheelchair and fallen recently, and felt her wheelchair positioning should be better.  During interview on 11/20/14, at 2:08 p.m. OT stated R47's position could be improved with a different wheelchair, however, insurance wouldn't cover a different wheelchair, however, insurance wouldn't cover a different wheelchair to the facility did not have another suitable wheelchair or R47 to try. The OT had reported concerns regarding lack of wheelchair equipment to the facility, and stated although at times R47 might be in good body alignment, she could benefit from a different wheelchair. OT had brought in a wheelchair vendor the previous week to demonstrate a wheelchair option that would be customizable for R47's needs, however, the facility's funding for new chairs was limited and was unable to provide		E SURVEY PLETED				
		245465	B. WING			11/2	24/2014
		ЛЕ		410 WEST MAIN STREET	CODE		
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F 309	During observation R47 was observed wheelchair seat approached about a third of the R47 to slouch in he During interview on member (FM)-A stawheelchair and falle wheelchair position During interview on stated R47's positiod different wheelchair cover a different whot have another stated although at the body alignment, showheelchair. OT had vendor the previous wheelchair option the R47's needs, howe new chairs was limited R47 with an approproached by the stated down in her wheelchair observed down in her wheelchair observed down in her wheelchair option the stated although at the stated alth	on 11/20/14, at 10:30 a.m., in her wheelchair. The beared too short, coming only way up R47's thigh, causing r chair and slide forward.  11/20/14, at 10:30 a.m. family sted R47 had slid out of her en recently, and felt her ing should be better.  11/20/14, at 2:08 p.m. OT on could be improved with a r, however, insurance wouldn't neelchair and the facility diduitable wheelchair for R47 to ported concerns regarding equipment to the facility, and imes R47 might be in good e could benefit from a different a brought in a wheelchair sweek to demonstrate a nat would be customizable for ver, the facility's funding for sted and was unable to provide wriate fitting wheelchair.  on 11/21/2014, at 9:30 a.m. in a slouched position, sliding hair while trying to propel allway.  11/21/14, at 1:53 p.m. the different hair was not aware of ed to lack of appropriate fitting	F3				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245465	B. WING		11/24/2014
	PROVIDER OR SUPPLIER	ΛE	4	TREET ADDRESS, CITY, STATE, ZIP CODE  10 WEST MAIN STREET  DSAKIS, MN 56360	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 309 F 312 SS=E	requested but not p	rovided. ARE PROVIDED FOR	F 309 F 312		12/18/14
00-L	A resident who is u daily living receives	nable to carry out activities of the necessary services to tion, grooming, and personal			
	by: Based on observareview, the facility fresidents (R25, R4 staff assistance to with dining. Findings include: R25's quarterly Min 10/16/14, identified impaired and require eating.  During observation 11/17/14, at 6:03 p. front of her, and a versent at the table plate of food was jup.m., 18 minutes las at down and assis NA-A got up from the piece of paper, and 6:52 p.m., 23 minutes assisted R25 to fini R25 was taken out	cion, interview, and document ailed to ensure 4 of 13 D, R46 and R58) who required eat, received timely assistance imum Data Set (MDS) dated R25 was severely cognitively red extensive assistance with of the evening meal on m. R25 had a plate of food in variety of liquids. No staff were to assist R25 to eat, and the est set in front of her. At 6:21 ter, nursing assistant (NA)-A ted R25 to eat. At 6:29 p.m. he stool, began writing on a walked away from R25. At les later, TMA-A sat down and sh her meal, and at 6:59 p.m. of the dining room. R25's utes, and ate approximately		F312: Facility reviewed R25, 40, 46, 58 for appropriate dining and interventions added as appropriate per review of resident care plans.  All other residents needed assist in dining room were assessed to assurall needed and appropriate intervent were in place. Resident seating arrangements were reviewed, no chrequired. Staffing was reviewed and adjusted in accordance with acuity a meal times to ensure appropriate stream in place to assist residents with meals.  Staff education was completed to enthat all staff were aware of appropriate diningroom conduct and providing droom assist to residents in a dignified manner.  Reviewed and revised Dignity Policy Procedure and Dining and Food Services.	the re that tions  langes and aff all  nsure ate lining ed

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY PLETED
		245465	B. WING		11/:	24/2014
	PROVIDER OR SUPPLIER	ИE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		.,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 312	R40's annual MDS was severely cognidependent on staff  During observation 11/17/14, at 6:04 p. R40. At 6:14 p.m., to feed R40 for four again to feed anoth later, at 6:25 p.m., until 6:48 p.m., and dining room. R40's R40 ate approxima  R46's annual MDS was severely cogniextensive assistance. During observation 11/17/14, at 6:03 p. at the dining room t liquids in front of he table to assist R40 when trained medicand started to feed the dining room at 6 front of the resident receiving assistance approximately 10%  R58's quarterly MD R58 was severely cognired extensive. During observation 11/17/14, at 6:03 p. at the dining room to 11/17/14, at 6:03 p. at the dining	dated 10/9/14, identified R40 tively impaired and totally with eating.  of the evening meal on m., NA-A got up from feeding NA-A returned and continued minutes, and then left R40 er resident. Seven minutes TMA-A sat down and fed R40 then wheeled her out of the meal lasted 44 minutes, and tely 90% of the meal  dated 8/21/14, identified R46 tively impaired and required the with eating.  of the evening meal on m. R46 was observed sitting table with a plate of food and the extra the to eat until 49 minutes later, eation aide (TMA)-A sat down R46. R46 was taken out of 6:57 p.m. R46's meal was in the for 49 minutes before the to eat, and the resident atters.	F 312	Policy and Procedure. The chang these policies were reviewed with team.  Audits will be conducted by the dimanager or her delegate 8x/wk for quarter to assure that compliance maintained by staff. The results of audits will be reviewed weekly dul DT meeting and then reviewed word team to evaluate the outcome audits.  Corrective action was completed 12/18/14	etary or one e is f these ring the with the	

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRU ING			OMPLETED
		245465	B. WING				1/24/2014
	PROVIDER OR SUPPLIER	ИE	•		RESS, CITY, STATE, ZIP CODE IAIN STREET IN 56360		
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F 312	6:09 p.m. (6 minuter R58 and gave her siminutes later, at 6:1 stool she was sitting table and began to p.m. (29 minutes la R58 until 6:49 p.m. out of the dining roominutes, and ate approximately 12 reusually feed the residents who need to be approximately 12 reusually feed the residents who need to be approximately 12 reusually feed the residents who need to be approximately 12 reusually feed the residents who need to five staff as residents who need dining room during stated the resident first, got fed first. Fon feeding one to the residents who are used to sitting out on the buring interview on stated residents should have their for sitting out on the buring interview on stated residents should have their for sitting out on the buring interview on stated residents should buring observatiff was not observatiff was not observatiff.	is later) NA-A sat down next to several bites of food. 3 12 p.m., NA-A wheeled the g on to the other side of the feed another resident. At 6:41 ter) TMA-A sat down and fed, at which time R58 was taken om R58's meal lasted about 46 oproximately 25% of the meal.  11/20/14, at 2:10 p.m. TMA-A sually four staff in the dining ening meal to assist esidents. TMA-A stated staff sidents who could eat the en move on to the other		12			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		245465	B. WING _		11/24/2014	
	PROVIDER OR SUPPLIER  NITY MEMORIAL HON	1E		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTI	ON
F 312 F 323 SS=D	with eating in a mar enhanced each res The policy did not a assistance to reside 483.25(h) FREE OF HAZARDS/SUPER The facility must en environment remain as is possible; and	nner that maintained or ident's dignity and respect. ddress providing timely ents.	F 3		12/12/1	4
	by: Based on observat documentation reviewaluate/re-assess multiple falls for 1 of accidents.  Findings include: R3's annual Minimus 9/18/14, indicated Fimpairment, require of daily living (ADL's of urine, and was no program. The falls dated 10/1/14, indicated	ion, interview, and ew, the facility failed to potential causative factors for f 3 residents (R3) reviewed for m Data Set (MDS) dated R3 had severe cognitive d assistance with all activities s), was frequently incontinent of on a scheduled toileting Care Area Assessment (CAA) eated R3 had a history of falls, g a sitting balance, and had an uring transition from sitting to		F323 Resident #3 was reassessed relater falls. New fall risk assessment comwith interventions added to care plater Kardex. Resident did not sustain a residual effects from fall.  Safety Risk Assessments complete all residents in the facility. Care plater were reviewed and updated to included added safety interventions.  The new Safety Risk Assessments completed on admission, quarterly significant change and annually by licensed staff. Any safety interventions changes will be transferred onto recare plan and kardex. The Resider Incident/Accident Policy and Processor.	an pleted an and any  ed on ans ade any  will be any  with  on sident at edure	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		SURVEY PLETED
		245465	B. WING		11/2	24/2014
	PROVIDER OR SUPPLIER	ME	4	STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	required the assist every two hours, of two hours with rour analyze previous fapattern/trend could did not instruct statinterventions in plate Review of the facili Review/Investigation had a fall at 10:20 R3 was last checked and R3 was asleep investigation informinterventions were prevent injuries dut the resident had not investigation, no ascurrent fall interventions were Review of the facili Review/Investigation R3 had a fall at 10:00 on during rounds a earlier and was asl investigation indicasister when R3 was after staff complete further investigation current fall intervenensure they were a interventions were Review of the facili Review/Investigation current fall intervenensure they were a interventions were Review of the facili Review/Investigation had a fall at midnight and a fall at mid	ance of staff with repositioning ifer/assist with toileting every ands at night, and staff was to alls to determine whether a be addressed. The care plan if on any further fall ce for R3.  Ity Incident Report on dated 9/7/14, indicated R3 p.m. The document indicated at 10:00 p.m. during rounds on the positioned. The nation indicated all safety in place and the goal was to ring self-transfer attempts and on injuries. There was no further esessment regarding any attions that were in place to appropriate, and no further put in place.  Ity Incident Report on dated 10/2/014, indicated 35 p.m. R3 had been checked pproximately 10 minutes eep at the time. The ated R3 was looking for her is restless, and R3 woke up and rounds. There was no on, no assessment of any attions that were in place to appropriate, and no further put in place.	F 323	new Morning Stand-up Mtg log wardeveloped and put into place to as follow-up has been completed for a specific issues. An intervention list issues and falls was developed as to aide staff in implementation of sinterventions following incidents. A incidents and accidents are review during daily Morning Stand-up Med The members present at the meet review current safety interventions place for the identified resident and assure that new interventions are at the conclusion of the meeting.  The facility administrator will audit resident incident/accident reports on an ongoing basis to assure that incidents/accidents have been thour eviewed and investigated. All incidents/accidents will be reviewed during weekly IDT as well to review during weekly IDT as well to review incident, investigation, and interventhat were put into place. A log of all incidents and accidents will be reviewed every quarter at the QA meeting. The assure compliance with the implementation of new interventior incidents and to assure that all incidents and accidents are investigated tho Any incidents that are the result of neglect, abuse, or maltreatment with reported to the state reporting age immediately by the licensed staff at to the administrator and DON.  The corrective action for this tag we completed on 12/12/14.	sure resident for skin a way afety II ed eting. ing will in d added all veekly all roughly d v the ntions I ewed his with dents roughly. II be ncy nd then	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING		· · · · · · · · · · · · · · · · · · ·	11/2	24/2014
	PROVIDER OR SUPPLIER	ME		4	TREET ADDRESS, CITY, STATE, ZIP CODE  10 WEST MAIN STREET  DSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	bruising to R3's right.  There was no furth assessment of any were in place to en and no further inter. The investigation of last toileted or repowas a trend with the During observation was sitting in her wout the window.  During interview on registered nurse (Fout of bed on 11/5/1 takes off the oxyge of bed.  During interview on nursing assistant (Nany falls or attempt the day shift.  During interview on stated there were in place after R3's fall assessment regard RN-B stated R3 ha comfort and decrearestlessness/agitationable to determine During interview on stated staff do rour which would possibly stated that should be safe to enter the stated that should be safe to enter the safe that should be safe to enter the safe that should be safe to enter the safe that should be sa	bed. The fall resulted in ht hand, wrist, and elbow. er investigation, no current fall interventions that sure they were appropriate, ventions were put in place. id not include when R3 was sitioned, to determine if there e other previous falls.  on 11/18/14, at 3:48 p.m. R3 heelchair in her room looking  11/20/14, at 9:41 a.m. kN)-C stated R3 had climbed 14, and gets restless and in tubing and self-transfers out  11/20/14, at 11:14 a.m. NA)-C stated R3 did not have is to get up out of bed during  11/20/14, at 2:01 p.m. RN-B is no new interventions put in its, and there was no ling any trends of R3's fall. in medication to improve	F3	323			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245465	B. WING			11/2	24/2014
	PROVIDER OR SUPPLIER	ΛE.		41	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET SAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325 SS=D	woke R3 up. RN-A were not thorough, falls could be improred the facility policy R dated 4/16/14, direct an investigation into accident/incident, a root cause of the investigation in the facility of the investigation in the facility of the	stated R3's fall investigations and the investigations of the ved.  esident Incident/Accident sted licensed staff to conduct to the cause of the end an attempt to identify the cident will be made.  NUTRITION STATUS DABLE  t's comprehensive cility must ensure that a stable parameters of nutritional y weight and protein levels,	F3	323			12/18/14
	by: Based on observat review, the facility fa with significant weig comprehensively as needs were met. Findings include:  R21 sustained sign developed multiple	ion, interview, and document ailed to ensure 2 of 3 residents that loss (R21 and R50) were essessed to ensure nutritional difficant weight loss and pressure ulcers, however no 21's nutritional status was			F325:  Residents 21 and 50 had a new nut assessment completed by dietary manager. Corresponding updates had been made to the care plan and kar All residents in facility were reviewed weight loss according to facility policy.  Staff education was completed to expressions.	nave rdex. rd for cy.	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,		LE CONSTRUCTION		SURVEY PLETED
		245465	B. WING			11/2	24/2014
_	PROVIDER OR SUPPLIER	ME		4	STREET ADDRESS, CITY, STATE, ZIP CODE 110 WEST MAIN STREET DSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 325	had an admission Mated 9/20/14, which cognitively impaired staff for eating.  R21's care plan data required assistance modified texture did The goal was to madirected to monitor.  A nutritional risk assidentified R21's weild a regular, pureed to make meal/food produced assessment also not staff and did not make meal/food produced foognitively impaired and was dependent anticipate needs. To were no pressure undersure under undersure undersure under undersure under undersure under undersure under undersure under undersure under under undersure under undersure under under undersure under under undersure under	o the facility on 9/15/14, and Minimum Data Set (MDS) h identified R21 was severely I and was totally dependent on ed 11/18/14, identified R21 with eating, received a et and was lactose intolerant. A intain weight and staff were food and fluid intake.  Sessment completed 9/23/14, ght was 159 pounds, received exture diet, and was unable to eferences known. The oted R21 was totally fed by a lake any attempt to feed  Skin Assessment dated R21 was chair fast, was lake any attempt to feed  Skin Assessment noted there licers on admission.  Pent/Monitoring form dated the presence of two left heel e wounds were noted to be interventions listed included as, discontinue the use of TED low under feet in the chair and do not include any dietary	F3	325	that all staff were aware of appropriation of the Significant Weight Land Dining and Food Service Police Procedure. The changes to these were reviewed with QA team. Educ was provided to dietary manager at team on policy changes.  Weight loss will be reviewed week dietary manager and will be discus with IDT team. The results of weig reports will be reviewed weekly du IDT meeting and then reviewed with QA team to evaluate the adherence facility policy.  Corrective action was completed of 12/18/14	dining ied the coss y and colicies cation and IDT ty by the sed ht loss ring the th the e to	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED		
		245465	B. WING _	<del></del>	11	/24/2014	
	PROVIDER OR SUPPLIER	<b>МЕ</b>		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 325	on 11/14/14 the We form noted the left to an untraceable le continuing to float he wheelchair remained facility identified the worse indicating the interventions were dietary to ensure agencourage healing.  R21's documented 9/17/14 159 pound 10/17/14 159 pound 10/15/14 151.5 10/22/14 149.5 a 6% decrease from 10/29/14 148.5 flagged as a 5.1% of 11/12/14 148 pound 11/19/14 146 poweight loss from 15  During interview on manager (DM)-A sther if a resident had and she would comassessments to enappropriate nutrition promote healing. Didentified at nutrition reviewed by the conthe computer syste for her when a resident had a resident had and she would comassessments to enappropriate nutrition promote healing. Didentified at nutrition reviewed by the conthe computer syste for her when a resident had a resident ha	s to be stage one, and the ned unchanged.  Dound Assessment/Monitoring heel wounds to have declined evel. The interventions of neels while in bed and in ed unchanged. Although the pressure ulcers had gotten ey were now unstageable, no changed, including contacting opropriate nutrition to  weights included the following: ds pounds ounds pounds which was flagged as in 159 pounds pounds which was also decrease from 156.5 pounds ounds which flagged as 8.2%	F 32	25			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245465	B. WING		11	/24/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 410 WEST MAIN STREET OSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 325	she had been notif pressure ulcers on although R21 had developed multiple reassessment of R been completed, n put into place nutri weight loss or aid i "It got missed."  During interview or registered nurse (F	22/14, with a loss of 6% and ied of the developed stage one 10/20/14. DM confirmed a weight loss of >5%, and had pressure ulcers, no 121's nutritional status had or had any interventions been tionally to prevent further in wound healing. DM stated, and 11/20/14, at 9:26 a.m. RN)-D stated no reassessment	F 3	225		
	after the weight los pressure ulcers. Figust been started of you on Monday, I recomply any documentation indicated the dietic regarding R21's we pressure ulcers. Refloor were the ones the Wound Assess review of the wound RN-D stated all the noted R21's left he been at a stage on and they should had In addition, RN-D so notified when R21'	ed of R21's nutritional status is or the development of the RN-D stated a supplement had in 11/17/14, "After I talked to ealized that I had not started nent." RN-D was unable to find in R21's record which ian had been consulted eight loss or worsening N-D stated the RN's on the responsible for completing ment/Monitoring forms. Upon d forms and descriptions, assessments which had el pressure ulcers to have e, had been staged incorrectly, we been staged at a stage two stated she had not been stage one to unstageable.				
	consulting dieticiar facility monthly or b low. D-A stated sh	n 11/20/14, at 10:46 a.m. n (D)-A stated she visited the bi-monthly if the census was e would expect to be notified if % or greater weight loss, or				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245465	B. WING		<del></del>	11/2	24/2014
	PROVIDER OR SUPPLIER	ЛE		4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	p.m. D-A stated she the development of because they were typically stage one pwarrant nutritional instated if a resident stage two or worse, interventions would unaware R21's left staged incorrectly, abeen on a nutritional and pressure ulcer.  The undated facility Dietician indicated a inform the DM and consultant dietician identified the DM was a list of residents wor four pressure ulcoweight loss.  R50's quarterly MD R50 was on a theraplanned weight loss supervision of one supervision of one supervision of one supplement) twice of R50's nursing Progindicated R50's Boot indicated R50's Boo	erview on 11/20/14, at 1:41 e had not been contacted after R21's pressure ulcers noted to be stage one, and pressure ulcers did not enterventions for healing. D-A had a pressure ulcer of a immediate nutritional be put into place. D-A was heel pressure ulcers had been and stated R21 should have all supplement for weight loss healing.  It policy titled Referrals to as problems arise, staff would the DM would inform as needed. Further, the policy ould provide the dietician with ho had a stage one, two, three feer, tube feedings or significant.  S dated 9/11/14, indicated enter the program, and required staff member for eating.  But titled Referrals to as program, and required enter the feedings or significant.  S dated 9/11/14, indicated enter the program, and required staff member for eating.  But titled Referrals to as program, and required enter the feedings or significant.  S dated 9/11/14, indicated enter the program, and required enter the program of the program o	F3	325			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245465	B. WING		····	11/2	24/2014
	PROVIDER OR SUPPLIER	ΛE		4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	11/15/14, indicated 0-100% at meals.  R50's weights in the indicated the follow 11/18/2014 - 136.0 11/11/2014 - 135.0 lt 10/28/2014 - 134.5 10/21/2014 - 142.5 lt 9/30/2014 - 142.5 lt 9/30/2014 - 145.0 lt During observation R50 was eating his ate all of his oatmet omelette, and drank During interview on stated she came to nurses maintained on supplements. D discontinue nutritior if they were eating to concerns. D-A state flag residents with wand the D-M monitors in the past 45 copossible restarting light During interview on stated R50's nutrition of the was not made at loss in the past 45 copossible restarting light During interview on stated R50's nutrition of the was not made at loss in the past 45 copossible restarting light During interview on stated R50's nutrition of the was not made at loss in the past 45 copossible restarting light During interview on stated R50's nutrition of the past 45 copossible restarting light During interview on stated R50's nutrition of the past 45 copossible restarting light During interview on stated R50's nutrition of the past 45 copossible restarting light During interview on stated R50's nutrition of the past 45 coposition of the pas	d intakes for 10/1/14, to variable intakes between e electronic medical recording:  lbs	F3	325			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245465	B. WING			11/2	24/2014
	PROVIDER OR SUPPLIER	ЛE		STREET ADDRESS, CITY, STATE, ZIP COI 410 WEST MAIN STREET OSAKIS, MN 56360	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 325	however, RN-B star supplement was be his recent weight lo During interview on stated R50 was tak because he had ga weights were monit bath aide was responsible to DM know of the stated she monitore quarterly and annual. The undated facility indicated residents periodically for the protential risk indicated (5# in one month) of (10# in three month the risk determination time when significated that the nursing docinsights into the nutbasis.  Review of the facility weight Loss dated would be considered loss if they had greated one month or great three months. The gave direction to:  Assess whether desirable  Assess laborated was responsible assess feeding the same and the supplementation in the same and the same a	en eating all of his meals, ted R50's nutritional ing restarted today related to ss.  11/21/14, at 9:08 a.m. the DM en off the supplement ined weight. She stated R50's ored by the bath aide, and the possible to let nursing know if a story loss, and then nursing should nutritional concern. The DM ed resident weights with the al MDS.  If policy titled Nutrition Risk would be assessed presence of nutrition risk. It is included weight loss, e.g., for cumulative weight loss, e.g., for cumulative weight loss, e.g., for cumulative weight loss, e.g., for cumulation should include the int weight changes occur, and cumentation should include the intrinsic problems on a regular story policy titled Significant 10/12/10, indicated residents after than 5% weight loss in the er than 7.5% weight loss in procedure within the policy or or not the weight loss was	F 3	25			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245465	B. WING	<del></del>	11/24/2014
	PROVIDER OR SUPPLIER	<b>ЛЕ</b>	4	STREET ADDRESS, CITY, STATE, ZIP CODE 110 WEST MAIN STREET DSAKIS, MN 56360	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTION
F 325 F 329 SS=D	potential causes.	of malnutrition. Identify  EGIMEN IS FREE FROM	F 325		12/16/14
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer	g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any e reasons above.			
	resident, the facility who have not used given these drugs therapy is necessal as diagnosed and crecord; and residendrugs receive gradubehavioral interven	chensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical its who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these			
	by: Based on observative review, the facility for (R1) who received (medications that he	NT is not met as evidenced tion, interview, and document ailed to ensure 1 of 1 residents multiple psychoactive drugs ave significant effect on mood clear indications for use. In		F329 Staff reviewed resident #1 s curre of medications and care plan. In e incorrect diagnosis was in place for Gabapentin. Chart and MD notes	rror,

PRINTED: 12/23/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		E SURVEY PLETED
	245465	B. WING		11/2	24/2014
NAME OF PROVIDER OR SUPPLIE  COMMUNITY MEMORIAL HO			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360	•	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
discharged reside medication orders use.  Findings include:  R1's quarterly Mir 10/23/14, identificing impairment, had a depression sever depression), and  R1's care area as psychoactive drug R1 had a history of prone to crying ar antidepressant] with the care resident expressions afety. The care resident expressions afety. The care non-pharmacolog distraction with accourage rosary R1's physician ord current medication with accourage rosary (mg) every day at dementia/schizop Buspar (an anxiolanxiety)	ty failed to ensure 1 of 1 ents (R72) with multiple pain is had appropriate parameters for  mimum Data Set (MDS), dated ed the resident had no cognitive a PHQ-9 (a test to determine ity) score of 2 (minimal exhibited no behaviors.  ssessment (CAA) for g use dated 5/16/14, indicated of psychiatric illness and was nd anxiety, and Cymbalta [an vas helpful.  Itted 11/21/14, indicated a risk ors related to diagnosis of phrenia, bipolar disorder, and plan identified goals of the ng a feeling of comfort and plan identified pical interventions for behavior of ctivities, exercise, 1:1 visits, v, and deep breathing.  Iders, dated 11/21/14, identified on orders including:  Inchotic medication) 10 milligrams to bedtime for ohrenia lytic) 20 mg twice daily for  anxiolytic) 0.5 mg three times	F 32	reviewed and correct diagnosis we placed. Resident was seen on 11/primary MD. All medications were reviewed. Dose reduction on one resident s psychotropic medication completed. Daily charting on mood/behaviors initiated for licens to monitor toleration of reduction.  Resident #72 had been discharge 11/4/14. With record review, it was that resident was on 2 different an without guidelines as to which me to use or how many tabs to admin harm was caused to resident during short term rehabilitation stay but in guidelines were given by the prima for type of analgesic to use first or different rates of pain.  Psychoactive med audit complete residents in facility to assure psychetications had received dose recorrect appropriate documentation from primary MD for justification for use were also completed on all reside facility to assure that any residents multiple analgesics with variable or anges had appropriate guidelines administration.  The DON reviewed and reviewed revised the Psychotherapeutic Merevised the Ps	of ons was sed staff d on snoted algesics dication ister. Nong the oary MD with d on all hotropic ductions of the soon lose of for and dication iges or and erly QA have	

Facility ID: 00109

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245465	B. WING		11/2	24/2014
	PROVIDER OR SUPPLIER	ME	4	STREET ADDRESS, CITY, STATE, ZIP CODE 110 WEST MAIN STREET OSAKIS, MN 56360	,	.,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329	Cymbalta (an antid for anxiety/depress Gabapentin (an antiby mouth twice dail in the morning and 200 mg daily at 1 p Klonopin (an anxiety Zoloft (an antidepreday for anxiety/dep Review of R1's beh October- November of feeling anxious, both were redirected distraction.  During observation was observed in behaviors of emotion was in the dayroom a flat facial express no adverse behaviors. During interview on and NA-D stated R behaviors, only occurred interview or registered nurse (Fany behaviors and During interview or consultant pharmaters.	epressant) 60 mg every day ion/peripheral neuropathy ticonvulsant/analgesic) 300 mg y for dementia/schizophrenia evening, and an additional .m. ytic) 0.5 mg by mouth daily as essant) 75 mg by mouth every ression avior monitoring sheets for r 2014, indicated two episodes and one episode of irritability, able with 1:1 visits or  on 11/17/14, at 2:20 p.m. R1 ed. R1 had a flat facial affect ttentive, and displayed no She did not express any al distress.  on 11/18/14, at 2:35 p.m. R1 in watching television. She had sion, was alert, and displayed	F 329	changes.  Facility Health Unit Coordinator won all new orders and log any orderequire added clarification to assiguidelines are in place on all medwith ranges and that appropriate diagnosis(es) are attached to all medications. Any concerns or inadocumentation will be brought uplicensed nursing staff and order clarification will be obtained wher required.  The Director of Nursing will monit psychotropic use in the building, orders will be audited by the Hea Coordinator for the inclusion of parameters and diagnosis.  The Director of Nursing will be responsible for facility compliance.  Correction for this tag was completed.	lers that ure that dications dequate to the tor the All new lth Unit	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			` '	E SURVEY IPLETED
		245465	B. WING			11/	24/2014
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME			A BUILDING  245465  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360  STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)  In page 77  See for R1's multiple psychoactive ated the medication indications ore defined as to exactly what einer defined as there were sees listed for the medications, and abapentin for schizophrenia Timoses. CP-A stated there was coist that came to the building he would have that pharmacist  A on 11/20/2014, at 4:16 p.m. Was doing well right now with her lid show some perseveration on a tell tit go. Her behaviors did not rroutine.  A on 11/21/14, at 10:25 a.m. CP-B, gularly scheduled consultant he facility, stated she monitored a effectiveness through "trial and were multiple diagnoses and ation class therapy for some of e drugs.  By titled Psychotherapeutic end 3/4/13, indicated a resident will shotherapeutic medications unless on is needed to treat a specific ach psychotherapeutic pe given to treat clearly defined				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
F 329	indications for use of drugs. CP-A stated needed to be more condition was being multiple diagnoses further stated Gaba would "never fly," in appropriate diagnose another pharmacist more often, and he return a call.  During interview on RN-B stated R1 was behaviors and did stopic and will not led disrupt her daily round buring interview on who was the regular pharmacist for the R1's medication efferor," as there were duplicate medication the psychoactive drug the medication will be garget behaviors. To duplicative drug the monitored and discontinuous discon	for R1's multiple psychoactive of the medication indications defined as to exactly what greated as there were listed for the medications, and apentin for schizophrenia indicating it was not an indicating it would have that pharmacist in 11/20/2014, at 4:16 p.m. In a doing well right now with her is show some perseveration on a it it go. Her behaviors did not utine.  In 11/21/14, at 10:25 a.m. CP-B, and arrived the consultant facility, stated she monitored facility, stated she monitored facility, stated she monitored facility, stated she monitored facility in the multiple diagnoses and in class therapy for some of rugs.  It is defined the properties of the properties of the policy further stated erapy would be closely four aged.		329			
		rogress note dated 11/5/14, ent was admitted to the facility					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION DING	(X	B) DATE SURVEY COMPLETED
		245465	B. WING			11/24/2014
	PROVIDER OR SUPPLIER  NITY MEMORIAL HOI	ME		STREET ADDRESS, CITY, STATE, ZIP 410 WEST MAIN STREET OSAKIS, MN 56360	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIAT	
F 329	to recover after fract admission minimum 11/11/14, identified impairment, had be pain medication, and R72's current care staff to ask the resident had concern the resident had concern from 11/5/14-11/18 Norco. Of the 43 second minimum 11/5/14-11/18 Norco. Of the 43 second minimum 11/11/15 Norco. Incompariment of the recover after the resident had concern from 11/5/14-11/18 Norco. Of the 43 second minimum 11/15/14-11/18 Norco.	cturing the coccyx. R72's in data set (MDS) dated R72 had no cognitive ten receiving PRN (as needed) and had frequent pain.  plan dated 11/14/14, instructed dent about pain and offer to minutes prior to therapy.  ment dated 11/4/14, indicated instant pain at all times, and in medications of Norco 5-325/4 hours, and Tylenol 1000 mg is summary of R72's painhas PRN Norco and Tylenol ain the use of PRN medication re to monitor her for non use to pain"  cian orders dated 11/14/14, prescribed the following PRN  one- Acetaminophen) 3-325/1 tablets, every 4 hours for might (Acetaminophen) 1000/ery 6 hours for pain.	F3	329		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPPI JER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		COMPLETED	
		245465	B. WING _		11/2	24/2014
	PROVIDER OR SUPPLIER	ΛE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 329	received Tylenol 10 of Norco, 2 tablets.  Tylenol 1000 mg, as 2 tablets.  During interview on stated when reside medication orders taking 1-2 tablets, t physician to obtain know what actual d should receive, or e usually will catch it review, however, R pharmacy review of to the facility. RN-E should have instructione Norco or two, a should receive Tyle  During interview on licensed practical nadministered R72 Ner 2 tablets becausignificant pain. LP have PRN pain medication to gresidents range of phave specific orders administered the pahow the resident was	nes. On 11/9/14, R72 00 mg, as well as two doses On 11/10/14, R72 received s well as two doses of Norco,  11/20/14, at 9:55 a.m. RN-B nts are admitted with hat included ranges, such as he nursing staff should call the specific orders to ensure staff ose of Norco the resident else the consulting pharmacist when doing the pharmacy 72 had not yet had a f medications since admission 8 stated R72's Norco order sted when R72 should receive as well as when the resident	F 32	29		
F 371 SS=F	requested, but not p 483.35(i) FOOD PF	provided.	F 37	71		12/11/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245465	B. WING		11/24	4/2014
	PROVIDER OR SUPPLIER	ME	4	TREET ADDRESS, CITY, STATE, ZIP CODE  10 WEST MAIN STREET  DSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	considered satisfac authorities; and (2) Store, prepare, under sanitary con-	om sources approved or ctory by Federal, State or local distribute and serve food	F 371			
	review the facility famachine in a sanital possibility of food be potential to affect a residing in the facilibasis from the ice.  Findings include:  During the initial kit 12:32 p.m. an ice routside the kitchen Inside the ice mack observed covering right corner where substance covered ice damper, distribustance which rathe back panel and already made ice sidietary manager (Esubstance, and states)	tion, interview, and document ailed to maintain the ice ary manner to minimize the borne illness. This had the all 36 residents currently ity who received ice on a daily machine.  The then tour on 11/17/14, at machine was observed just, in the facility dining room. The facility dining room the ice was made. The green the water pump, water trough, ution tube, and evaporator. In the two trickles of the green an from the components down I disappeared behind the itting in the ice machine. The DM) verified the green ted the ice machine had just dining room from the assisted		F371 Upon notification of concerns with faice machine, the maintenance direct cleaned and sanitized the facility ice machine.  All residents who had water delivered morning of 11/18/14, had their water glasses replaced and filled with cleat after the ice machine was cleaned. I harm or illness resulted from the issemble like the ice machine was developed. The manufacturer is guide specific to the machine was connected and placed the rear of the ice machine.  Manufacturer is guidelines recommic cleaning every 6 months. Maintenar director developed audit log and will cleaning facility ice machine every quite which is actually more frequently the manufacturer is guidelines. This autilise attached to the rear of the ice.	ed the run ice No sue.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245465	B. WING		11/2	24/2014	
	PROVIDER OR SUPPLIER	<b>ЛЕ</b>		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE	
F 371	During interview on Maintenance (M)-A moved in the dining 11/14/14. M-A state machine to the faci room, he rinsed the but did not take it a scrub off the green green substance w wasn't 100% certain During a follow up of 10:37 a.m. the gree in the ice machine was to the substance was turned the finger of green substance was turned to the green substance was turned to the green	/14/14, so there was not a set up yet.  11/17/14, at 1:29 p.m. stated the ice machine was groom at the facility on ad when he brought the ice lity and installed it in the dining machine quickly with bleach, part, made no attempts to substance. M-A thought the as a copper build up, but in.  Observation on 11/18/14, at en substance was still present. The green substance in the uched with a gloved hand, and able to be rubbed off and the white glove green, and the as able to be removed just by moved the machine from ad the ice that had been given dier in the day in pitchers of were removed from their	F 371	machine. The changes and implementation of the new cleanir was reviewed during the QA meet Corrective action for this tag was completed on 12/11/14.			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION  NG		E SURVEY IPLETED
		245465	B. WING _		11/	24/2014
	PROVIDER OR SUPPLIER	ΛE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER OF THE APPROPRICE OF THE	LD BE	(X5) COMPLETION DATE
F 425 F 425 SS=D	ACCURATE PROC  The facility must prodrugs and biological them under an agre §483.75(h) of this punlicensed personn law permits, but only supervision of a lice. A facility must provide (including proceduracquiring, receiving administering of all the needs of each receiving and t	RMACEUTICAL SVC - EDURES, RPH  Divide routine and emergency als to its residents, or obtain rement described in art. The facility may permit all to administer drugs if State y under the general rensed nurse.  Description of the description o	F 4:			12/5/14
	a licensed pharmacon all aspects of the services in the facility.  This REQUIREMENT by: Based on observat review, the facility for residents, (R25, R3) patch (a narcotic parand accurate admirto ensure the residemedication as presented.	aploy or obtain the services of sist who provides consultation a provision of pharmacy sty.  AT is not met as evidenced sion, interview, and document ailed to ensure 2 of 2 and a fentanyl sin medication) had consistent sistration and destruction plan sent was receiving the cribed, as well to ensure the ere destroyed to prevent		F425 On 12/16/14, the pharmacy cons was in building for monthly visit a reviewed narcotic ledger for accu Fentanyl patches. All recent entring resident #25 and 37 involving Fe had appropriate documentation in double signatures. No irregulariti noted on recent Fentanyl entries. Resident #37 was discharged to assisted living facility on 12/12/14	nd iracy of es on ntanyl ncluding es were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245465	B. WING			11/2	24/2014
	PROVIDER OR SUPPLIER	ΛE		41	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET SAKIS, MN 56360	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	R25's quarterly Min 10/16/14, identified cognitive impairment medication, and hapain.  R25's current physical indicated Fentanyl for pain. The Fentation 2/5/13.  Review of R25's Indicated a Fentanyl 1/25/14, and the neuntil 1/30/14, five of Medication Administindicated R25 recein 1/25/14, 1/28/14, and During interview on registered nurse (Rwhy R25's narcotic match indicating where evived the Fentanyl had not been off.  R37's admission Match the resident had mown as on a scheduled medication, and had R37's current physical indicated Fentanyl for pain.  Review of R37's Inc.	imum Data Set (MDS) dated the resident had severe nt, was on scheduled pain d no signs or symptoms of cian orders dated 11/17/14, 25 mcg patch every 72 hours anyl prescription was started dividual Narcotic Record patch was administered on xt patch was not administered lays later. However, R25's tration Record (MAR), ved a Fentanyl patch on	F 4	25	On 12/16/14 the pharmacy consultate audited all residents in the facility receiving Fentanyl. No other recent irregularities or concerns were noted. The DON reviewed and reviewed at revised the Medication Error Policy Procedure on 12/1/14 and Daily Nate Medication Count and Use of Narco Patches Policy and Procedure on 1 Pharmacy consultant and medical of present for Quarterly QA meeting of 12/16/14. Changes in the policies were viewed. A new Medication Error Formulation was developed and put into use on 12/5/14. This new form will allow the member making error to review and off that the error has been acknowled and education was given. Licensed have been education on new policy procedures changes related to medication. Facility staff review narcotic counts review bound narcotic ledger each stadily. The Pharmacy Consultant will the facility bound narcotic ledgers emonth to assure that the documentarelated to administration and destrupolicies of fentanyl continues to be followed by facility staff. Any discrepancies in medication errors of brought to the attention of the DON appropriate follow up, investigation, education, etc per medication error occur.  The corrective action for this tag was completed on 12/5/14.	d.  nd and rcotic otic 2/5/14. director n ere deport e staff d sign edged staff and dication and shift l audit very ation ction will be and will	

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		245465	B. WING _			/24/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 410 WEST MAIN STREET OSAKIS, MN 56360		
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F 425	9/14/14, and the neuntil 9/20/14, six differential patch on was not administer later. The Fentany off by two nurses with policy on 9/8/14, 9/14 there was only one next to it was, "No Review of R37's Mindicated the reside on 9/14/14, and did until 9/20/14, six da October 2014, indipatch on 10/8/14, 10/13/14.  The facility provide for R37 which iden 10/12/14. No patch were not reordered applied" 10/19/14- "During Mentanyl patch from resident's left should buring interview or stated R37 was to every 72 hours for determine why the didn't match, and straining regarding of administration and patches. RN-A statraining several modernic several moder	ext patch was not administered ays later. R37 received a 10/9/14, and the next patch red until 10/13/14, four days of patches were also not signed when destroyed per facility (26/14, 10/2/14. On 10/13/14, a nurse's signature, and written patch to remove."  AR for September 2014, ent received a Fentanyl patch of not receive the next patch ays later. R37's MAR for cated R37 received a Fentanyl 10/9/14, 10/12/14, and again on the days later of the following:  All patch due to be changed on the available to apply Patches of when last patch was a family of the following of the fo	F 42	25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245465	B. WING _		11/	24/2014
	PROVIDER OR SUPPLIER	ΛE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	) BE	(X5) COMPLETION DATE
F 425	were instructed two off the destruction of stated the facility dispatch destruction parts a policy on destroying witness.  During interview on consulting pharmace goes to the facility, Fentanyl patch cours Book, to ensure the correct. CP-G stated documentation system when the resident at CP-G stated two numbers a Fentanyl paresident and destromore education for	nurses must witness and sign of Fentanyl patches. RN-A d not have a specific Fentanyl olicy, however, the facility had ng all medications with a 11/26/14, at 10:00 a.m. sist (CP)- G stated when she she reviews the current along with the Narcotic Fentanyl patch count is	F 42	25		
F 428 SS=D	dated 11/5/09, instrinarcotic medication another nurse, and destroyed by two lic in the sewer system 483.60(c) DRUG R IRREGULAR, ACT  The drug regimen or reviewed at least or pharmacist.  The pharmacist muthe attending physic	EGIMEN REVIEW, REPORT	F 42	28		12/16/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMF	
		245465	B. WING		11/2	24/2014
	PROVIDER OR SUPPLIER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DSAKIS, MN 56360	,	
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F 428	Continued From page 1	age 86	F 428			
	by: Based on observareview the consultation of	mum Data Set (MDS), dated of the resident had no cognitive PHQ-9 (a test to determine y) score of 2 (minimal exhibited no behaviors.  Sessment (CAA) for use dated 5/16/14, indicated f psychiatric illness and was d anxiety, and Cymbalta [an as helpful.  ed 11/21/14, indicated a risk is related to diagnosis of the grant and colan identified goals of the grant		F428 Staff reviewed resident #1 s curre of medications and care plan. In elincorrect diagnosis was in place for Gabapentin. Chart and MD notes reviewed and correct diagnosis was placed. Resident was seen on 11/2 primary MD. All medications were reviewed. Dose reduction on one or resident s psychotropic medication completed. Daily charting on mood/behaviors initiated for license to monitor toleration of reduction. Psychoactive med audit completed residents in facility to assure psych medications had received dose redor appropriate documentation from primary MD for justification for use, were also completed on all resident facility to assure that any residents multiple analgesics with variable doranges had appropriate guidelines administration.  The DON reviewed and reviewed a revised the Psychotherapeutic Medical director pharmacy consultant during quarte meeting. All licensed nursing staff is been made aware and have been educated on policy and procedure changes.	fror, 6/14 by fns was ed staff on all otropic luctions Audits ts in on ose for and lication ges r and rly QA	

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		245465	B. WING _		11/	24/2014
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CO 410 WEST MAIN STREET OSAKIS, MN 56360	<b>.</b>	21/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	current medication  Abilify (an antipsyc) (mg) every day at be dementia/schizoph Buspar (an anxioly) anxiety Clonazepam (an andid for anxiety/depress) Gabapentin (an andid for anxiety/depress) Klonopin (an anxiety/depress) Gay for anxiety/depress Gabapentin (an andid for anxiety) All for anxiety A	ers, dated 11/21/14, identified orders including: hotic medication) 10 milligrams bedtime for renia tic) 20 mg twice daily for exiolytic) 0.5 mg three times mentia epressant) 60 mg every day ion/peripheral neuropathy ticonvulsant/analgesic) 300 mg by for dementia/schizophrenia evening, and an additional evening, and an additional evening. The most process of the m	F 42	Facility Health Unit Coordina on all new orders and log any require added clarification to guidelines are in place on all with ranges and that appropridiagnosis(es) are attached to medications. Any concerns of documentation will be brough licensed nursing staff and order clarification will be obtained or required.  The Pharmacy Consultant with review the drug regimen of a residents monthly with updat forthcoming to provider.  The Director of Nursing will be responsible for facility complication for this tag was contained.	y orders that assure that medications iate of all or inadequate at up to the der when the derivation of the derivation o	
	was observed in be	on 11/17/14, at 2:20 p.m. R1 ed. R1 had a flat facial affect ttentive, and displayed no				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING			11/2	24/2014
	PROVIDER OR SUPPLIER	ИE		4	STREET ADDRESS, CITY, STATE, ZIP CODE 110 WEST MAIN STREET DSAKIS, MN 56360		
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F 428	feelings of emotion.  During observation was in the dayroom a flat facial express no adverse behavior.  During interview on and NA-D stated R behaviors, only occ.  During interview on registered nurse (R any behaviors and During interview on consultant pharmac some "legitimate coindications for use drugs. CP-A stated needed to be more condition was being multiple diagnoses further stated Gaba would "never fly," in appropriate diagnoses further pharmacist more often, and he return a call.  During interview on RN-B stated R1 was behaviors and did stopic and will not led disrupt her daily round interview on During Intervi	She did not express any al distress.  on 11/18/14, at 2:35 p.m. R1 watching television. She had ion, was alert, and displayed ors.  11/18/14, at 3:26 p.m. NA-A did not have a lot of asional tearfulness.  11/20/14, at 11:18 a.m., encorrection of the routine.  11/20/2014, at 4:11p.m., the cist (CP)-A stated there were oncerns" with the diagnosis or for R1's multiple psychoactive of the medication indications defined as to exactly what go treated as there were listed for the medications, and upentin for schizophrenia edicating it was not an eses. CP-A stated there was a that came to the building would have that pharmacist  11/20/2014, at 4:16 p.m. s doing well right now with her show some perseveration on a tit go. Her behaviors did not	F 4	128			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING		11,	/24/2014	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360	·		
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ph R er du th Ti M no su comma ta du m F 441 SS=D Ti In sa to of (2 sh (3 ac (b) (1))	al's medication efforor," as there wer uplicate medication he psychoactive drawing the facility policy tital dedications dated for receive psychotouch a medication is condition, and each nedication will be garget behaviors. The uplicative drug the nonitored and disconsitored and disconsitored and disconsitored and disconsitored and disconsitored and disconsitored and infection Control Practice, sanitary and control practices and infection Con	facility, stated she monitored rectiveness through "trial and rectiveness through "trial and remultiple diagnoses and on class therapy for some of rugs.  Itled Psychotherapeutic 3/4/13, indicated a resident will therapeutic medications unless is needed to treat a specific respectivent of the policy further stated for policy furt	F 4	28		12/5/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
245465			B. WING		11/24/2014	
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F 441	communicable dise from direct contact direct contact will tr (3) The facility mus hands after each d hand washing is in professional practic (c) Linens Personnel must ha	the prohibit employees with a lease or infected skin lesions with residents or their food, if ransmit the disease. It require staff to wash their irect resident contact for which dicated by accepted	F 44	1		
	by: Based on observareview, the facility from th	NT is not met as evidenced tion, interview, and document ailed to ensure proper siques to prevent cross of 2 residents (R53, R47) ersonal cares, and for 1 of 1 erved during a glucometer of S dated 9/18/14, identified the extensive assistance of two ygiene and toileting.  On 11/19/14, at 8:12 a.m. the sistant (HNA) and nursing ere providing personal cares to d R50's urinary catheter bag oved hands, dumped the urine sed the urinal with water, water into the toilet. HNA then		F441 Residents #53, 47, and 16 have to reviewed for potential negative out from the lack of proper handwash witnessed on 11/18, 11/19 and 11 No adverse outcomes noted to the 3 residents.  Infection control reports reviewed 12/16/14 and no trend of an incredinfections including UTL is or other illnesses in facility were noted.  The Blood Glucose Policy and Proving was reviewed and revised. The fact Hand-washing Policy and Proceding reviewed but did not require any in the quarterly QA team met on 12 and reviewed all infections in facility past quarter. No increase in infections	on ase in er occedure acility ure was revisions. 1/16/14 lity this	

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F 441	bathroom and rem washing her hands bedside and proce resident side to sid gloves and took at R50's skin during became visibly soi After wiping R50, I threw them in the hands, NA-E procemechanical lift slin resident's shoulde the process.  During interview of confirmed she had removing the soile hands immediately HNA stated she had remove after enurine, however, had her gloves after enurine, however, had have.  R47's quarterly Min 8/18/14, identified impairment, requir activities of daily linicontinent of bow During observation nursing assistant (observed providing and NA-B had glow turn on her right sincontinent production and NA-F used se R47's perineal are	the garbage can in the loved her gloves. Without is, the HNA returned to the leded to help NA-E roll the defor peri care. NA-E applied in incontinent wipe to cleanse peri-care. NA-E's gloves led with stool when wiping R50. NA-E removed her gloves and garbage. Without washing her leded to hook R50 up in a g, touching the sling, the res, and the shower chair during in 11/19/14, at 8:25 a.m. NA-E is not washed her hands after d gloves and would wash her after she left the room. The lad, "thought about" removing inptying R50's catheter bag of and not done this and should inimum Data Set (MDS) dated R47 had severe cognitive ed extensive assistance with all living (ADL'S), and was	F 4	141	trends was noted by the team and medical director.  Hand washing audits during cares, and nursing treatments were put int place and continue to be ongoing a employees arrive for scheduled shift employees will be audited to assure hand washing is completed accurat and according to facility policy. 10 H washing audits will continue weekly one quarter to assure that staff rem compliance with hand washing polic results of the audits will be brought reviewed at the next QA meeting.  Education on Handwashing was proto staff on 11/25 and 12/2/14. Hand washing audits during cares, meals nursing treatments were put into pla and continue to be ongoing as emparrive for scheduled shifts. These awill be reviewed by the Director of Neekly and the results brought to Quemployees will be audited to assure thand washing is completed accurat and according to facility policy. 10 H washing audits will continue weekly one quarter to assure that staff rem compliance with hand washing polic The Director of Nursing is responsit compliance.  Correction for this tag was completed 12/5/14.	to s fts. All e that rely dand for ain in cy. The to and covided dace loyees audits lursing that rely dand for ain in cy. ole for ole for	

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F 441	soiled gloves, NA-FR47's bedside stan ointment, unscrewe squeezed ointment hand, replaced the on the bed, and rub perineal area. With picked up the tube opened the drawer, the drawer, and puremoving the glove package of disposatossed them onto the removed the soiled continued to assist product on. NA-F the and continued to assist product on. NA-F the and continued to as R47. R47 was lying protect the bed, and soiled with stool, Napants up, sliding the NA-B removed her positioned R47 onto transfer lift, touchin wheelchair and foo curtain. R47 was to the wheelchair. NA-her glasses on. With opened the door to handle, and then puin the wheelchair, to wheelchair. NA-F picked up the clothiand secured the clothiand secured the clothiand secured the clothiand secured items.	Without removing the visibly opened the top drawer on d, picked up a tube of ed the cap of the tube, from the tube into her right cap on the tube, laid the tube obed the ointment on R47's out removing the gloves, NA-F of ointment from the bed, put the tube of ointment into shed the drawer shut. Without s, NA-F picked up the able wipes from the bed, and he bedside stand. NA-F glove on her right hand, and to put R47's clean incontinent hen removed the left glove, sist NA-B to turn and dress on top of a pad used to d although this pad was visibly A-F and NA-B pulled R47's em across the soiled pad. gloves, and NA-F and NA-B of a canvas sling used for the g the sling, the lift, R47's topedals, and the privacy ransferred and positioned into across the soiled pad. For the grant positioned into thout washing her hands, NA-F R47's room touching the door ushed R47 to the dining room ouching both handles on the ositioned R47 at the table, ing protector, placed it on R47, othing protector around R47's back to R47's room, pulled to bed, touched the pillow, on the bedside table, and at contained the soiled linens	F 4	41			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	` '	(X3) DATE SURVEY COMPLETED		
		245465	B. WING		11/24/2014			
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F 441	product, and carrie hallway, to a closed then threw the bags disposing of the bas sanitizer to clean houring interview on stated she touched gloves during R47's gloves after providiverified she did not removing her soiled many items in R47'R47's room. NA-F changed gloves aft and should have woremoving the glove During interview on registered nurse (F concerns with period the NA were provided had re-posted the policy in the soiled review. RN-B states change their gloves cleaning a resident.  The facility policy ti 5/10/14, directed stand contact with a resident personal proton hand contact with the infectious materials.  During observation licensed practical in blood glucose check the policy in the soiled review. RN-B states change their gloves cleaning a resident.	tained the soiled incontinent d the two bags through the d door that she opened, and into receptacles. After gs, NA-F then used hander hands.  11/19/14, at 8:43 a.m. NA-F many items with the soiled is cares and did not remove her ng personal cares. NA-F wash her hands after d gloves and before touching is room, as well as outside of stated she should have er providing personal cares, ashed her hands after s.  11/20/14, at 1:50 p.m.  11/20/14, at 1:50 p.m.  11/20/14, at 1:50 p.m.  11/20/14 at 1:50 p.m.	F 44	1				

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F 441	the test strip, and we finger with a cotton gloves during this to read, LPN-B brough cotton ball, and land medication/treatment the left hand, and under right hand. The glucometer was play LPN-B proceeded to computer on top of any hand hygiene.	, placed a sample of blood on viped the blood from R16's ball. LPN-B was not wearing ime. After the results were ht the glucometer, test strip, cet back to the ent cart, carrying the supplies in unlocked her cart with keys in e items were disposed of, the aced back in the cart, and to enter data onto her the cart without performing	F 441			
F 465 SS=D	cart, discard the so perform hand hygie computer. LPN-By hand hygiene after glucose testing.  A facility policy regardlucose testing was 483.70(h) SAFE/FUNCTION/E ENVIRON	would typically return to her biled items appropriately, and ene prior to touching the everified she did not perform performing R16's blood earding hand hygiene and blood is requested but not provided.  AL/SANITARY/COMFORTABL	F 465		-	12/16/14
	sanitary, and comforesidents, staff and This REQUIREMED by: Based on observareview the facility fa	rovide a safe, functional, ortable environment for I the public.  NT is not met as evidenced tion, interview, and document ailed to ensure resident clean for 1 of 1 residents (R21)		F465 The wheelchair armrest for R47 wa	as	

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	PROVIDER OR SUPPLIER	ЛЕ		41	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET SAKIS, MN 56360	/ -	., =
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	observed with a soi facility failed to ens repair for 1 of 1 res torn armrest.  Findings include:  On 11/18/14, at 9:3 noted to be full of d of the wheelchair, a hand corner.  On 11/20/14, at 10: in the wheelchair in and dust were note wheelchair.  On 11/20/14, at 1:4 observed R21's wh dirt and debris preshousekeeping, a column Log (West) was proand December 201 wheelchairs were to the cleaning schedid documentation of bootober or November Month Wheelchair requested and recesseptember 2014, a washing of R21's well-washing of R21's well-washing through to and clean. M-A state on R21's wheelchair washing through to and clean. M-A state on R21's wheelchair washing through the state on R21's wheelchair washing through the state of R21's wheelchair washing through the state on R21's wheelchair washing through the state of R21's wheelchair washing the state of R21's wheelchair washing through the state of R21's wheelchair washing the state of R21's wheelchair washing through the state of R21's washing thro	led wheelchair. In addition, the ure wheelchairs were in good ident (R47) observed with a 5 a.m. R21's wheelchair was ebris and crumbs on the pad appeared soiled on the right 58 a.m. R21 observed sitting the activities area. Debris d below the seat of the 6 op.m. maintenance (M)-A eelchair and verified there was ent. After consulting with app of the Wheelchair Washing ovided for October, November, 4, which indicated all resident of be washed twice a month on alle. R21's wheelchair had no eing cleaned / washed during over. A copy of the Twice a washing Log (West) was sived for May 2014 through and the last documented theelchair was on 9/18/14. Reeping should be the wheelchairs twice per and if they are heavily soiled, maintenance to take apart ted he has not done cleaning	F 4	.65	replaced on 11/24/14 by the maintedirector. The wheelchair of R21 wimmediately cleaned following soil identification.  All resident rooms and equipment visually inspected by the houseked and maintenance staff.  The policy and procedure for wheel washing was revised and a cleaning check list for the Housekeeping starevised to include the cleaning of the wheelchairs. The policy for Cleani Maintenance for CMH resident rool annual and daily maintenance was modified. The CMH policy was moon to include equipment repair and maintenance, procedure and preventient and procedure and preventient on 12/16/14.  The maintenance director will audic cleaning logs weekly for a quarter assure compliance with the update and procedure. The results of these audits will be reviewed at QA.  The Director of Maintenance is responsible for compliance.  Corrective Action Completed: 12/1	were ping lchair g aff was ne ng and ms for also odified entative ne QA at the so do policy se	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		245465	B. WING		11/2	24/2014
	PROVIDER OR SUPPLIER	ЛЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	nursing home shall down as needed, as month according to schedule.  During observation R47's wheelchair warmrest, with exposuncleanable surface.  During observation R47's wheelchair wexposed foam on the noted to be frayed.  During interview on M-A stated R47's warmrests and he trieresident equipment require repairs, how schedule of inspect notify him if they sate to be fixed.  During interview on administrator stated monitored for equipwith issues as soon them. He was unaw R47's wheelchair as uncleanable.  The undated facility Repair and Mainten would conduct mon	all wheelchairs within the be inspected each shift, wiped and washed at least twice a the wheelchair washing  on 11/20/2014, at 10:30 a.m. as observed with a torn left sed foam which created an e.  on 11/21/2014, 9:30 a.m. as again observed with ne left arm rest which was also  11/24/2014, at 12:26 p.m. heelchair needed new ed to visually inspect all in disrepair which would wever, there was no maintence ion. MA-A stated staff were to w any equipment that needed  11/21/2014, at 2:03 p.m. the different in disrepair and dealt as they became aware of ware of any concerns with remrest that was torn and  12 policy titled Equipment lance indicated maintenance thly equipment checks and	F 4	65		
F 490	repair equipment as 483.75 EFFECTIVE		F 4	90		12/18/14

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING			11/24/	2014
	PROVIDER OR SUPPLIER	1E		STREET ADDRESS, CITY, STATE, ZIP 410 WEST MAIN STREET OSAKIS, MN 56360	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIA		(X5) OMPLETION DATE
F 490 SS=F	ADMINISTRATION  A facility must be accenables it to use its efficiently to attain or practicable physical well-being of each or this REQUIREMENT by:  Based on interview administrator failed monitor care and sed development, impleabuse prohibition pracility. This had the residents currently frindings include:  Refer to F224, as the to ensure 5 of 8 resund R12) who made neglect, and/or misprovided follow up a further staff abuse flack of identification residents, resulting residents from staff abuse, as well as the interventions to present the residents currently remained at risk of and/or mistreatment.	PRESIDENT WELL-BEING  Idministered in a manner that resources effectively and or maintain the highest land, and psychosocial resident.  In it is not met as evidenced and document review, the to adequately oversee and ervices related to the imentation, and evaluation of olicies and procedures in the residing in the facility.  The facility administration failed idents (R52, R58, R44, R47 is allegations of staff abuse, treatment were protected and and resolution to prevent from occurring. The facility's a of staff mistreatment to in lack of protection for neglect, mistreatment, and its lack of developing vent further staff abuse, residing in the facility who potential staff abuse, neglect,	F 4	F490 It is the policy of CMH that administered in a manner to use its resources effecti efficiently to attain or main practicable physical, menti psychosocial well-being of Vulnerable adult reports w state agency on residents 11/19/14 and reports filed #52, 58, and 44 on 11/21/1 were thoroughly investigati results of those investigati to the state agency within requirements of the 5 work Internal facility investigation termination of 2 employee employee was suspended training on resident transferent education. The two employee required addition education. The two employer received further education return to work after the education termination of the state agency within a complete additional education. The two employees required additional education affected further education return to work after the educatio	that enable ively and tain the high reach resident feach regulations were fithe regulations were fithe regulations. One feach	es it phest dent. the 12 on ts orts illed ion e urther e tia wed to	

PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	11/24/2014	
STREET ADDRESS, CITY, STATE, ZIP CODE		
PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLÉTION	
initiated and completed on all resid #52, 58, 44, 47 and 12 to monitor for changes in psychosocial wellbeing concerns or effects from the filed rewere noted.  Interviews conducted with all nursing on 11/19/14 and interviews conducted with all residents in the facility on 1 to identify other potential cases of meglect or mistreatment. During resinterviews, one incident was report Incident was immediately reported agency. The incident was then investigated per Vulnerable Adult Pland procedures. Staff member involved was suspended and received addit training on transfers prior to her retwork schedule. Safety Risk assess were completed on all residents an plan changes were adjusted.  Zero Tolerance statement initiated facility administrator. Vulnerable Adpolicy and Procedure was reviewer revised to include the protection of residents during an alleged act of abuse/neglect. Changes include immediate removal and/or suspensialleged perpetrator. All licensed stareceived training and direction on house the state agency. An in-service training trained consultant was conducted for Vulnerable Adult and Abuse. The education included reviewing the hoppy of the updated Vulnerable Adult and Policy of the updated Vulnerable Adult Policy of the updated	or any No eports  Ing staff ted 1/20/14 resident sident ed. to state  Policy blved ional iurn to ments id care  by dult d and  sion of aff now to to the g by a for staff is ard ult	
	STREET ADDRESS, CITY, STATE, ZIP CODE  410 WEST MAIN STREET  OSAKIS, MN 56360  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPIDEFICIENCY)  initiated and completed on all resid #52, 58, 44, 47 and 12 to monitor from the filed rewere noted.  Interviews conducted with all nursing on 11/19/14 and interviews conducted with all residents in the facility on 1 to identify other potential cases of a neglect or mistreatment. During resinterviews, one incident was report Incident was immediately reported agency. The incident was then investigated per Vulnerable Adult P and procedures. Staff member invocedures. Staff member invocedures and procedures and procedures and plan changes were adjusted.  Zero Tolerance statement initiated facility administrator. Vulnerable Active and plan changes were adjusted.  Zero Tolerance statement initiated facility administrator. Vulnerable Active and plan changes were adjusted.  Zero Tolerance statement initiated facility administrator. All licensed state agency. An in-service training trained consultant was conducted for Vulnerable Adult and Abuse. The education included reviewing the high state agency. An in-service training trained consultant was conducted for Vulnerable Adult and Abuse. The education included reviewing the high state agency.	

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING	i		11/2	24/2014
	PROVIDER OR SUPPLIER	ЛЕ		4	STREET ADDRESS, CITY, STATE, ZIP CODE 110 WEST MAIN STREET DSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 490	investigation, report however, not all alle "Result in injury." The was aware reside communication with desired by the residestaff are aware the administrator immeresident mistreatmen, if it rises to the report it [to the state verified no reports agency in past 4 medical been a total of 3 reports, none of whistreatment to resisted they have a management feels well, and they have their staff would mistreated on injuries assisting staff to recresidents, and when	understood the process of ting, and resident protection, egations of mistreatment, he administrator also stated lents have felt that staffs in them have been, "Less then lent." The administrator stated need to report to the diately any allegations of level of mistreatment, we eagency]." The administrator had been filed with the state onths, and there had only borts made in the last 8 hich had to do with staff idents. The administrator wery small facility, so the like they know there staff very no reason to believe any of streat any of the residents.  Interview on 11/21/14, at 1:47 tor stated the facility had been of unknown origin, and cognize bruising injuries to in to report them. Reporting other types of potential abuse	F	490	including examples of physical, ver and emotional abuse. The staff we educated on the new disciplinary procedures during reports of allege abuse. The new Abuse Protocol fol were also reviewed and the contenthem were discussed at the inservidirector of nursing conducted 2 stameetings to review Vulnerable Aduand procedures. Policy and Proced Morning Standup, Weekly IDT, and Quality Assurance were reviewed a revised to include added communicand review of incidents and Vulnera Adult trends. Grievances and or incident will be reviewed on a daily basis duthe Morning Standup Meeting and with the IDT team which is led by the facility administrator. All unresolve grievances will be reviewed quarter the QA team for further review and direction for resolution. An incident was developed and put into place to Director of Nursing. All incidents wireviewed during Morning Standup at then the incident will be placed on the record. The log will be reviewed we during IDT and quarterly with QA to assure that all incidents are fully investigated and complete. A new grievance form was developed and onto place. Staff were educated by director of nursing on the location a proper use of the new facility grieval forms.  Staff education of Vulnerable Adult and Procedure will continue through	re also ed ders ts of ce. The ff It policy lures of I end cation able cidents ring weekly ne d end che log eekly I put the and cance Policy	

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245465	B. WING		11	/24/2014	
	ROVIDER OR SUPPLIER	1E		STREET ADDRESS, CITY, STATE, ZIP CO 410 WEST MAIN STREET OSAKIS, MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR  (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 490	Continued From pa	ge 100	F4	QAPI. During resident councilizing the policy and Procedure and grocedure took place. All ID minutes will be reviewed quated QA team to review incidents trends of abuse. Upon this revisions and/or staff educat implemented indicated via pwritten action plan. New empackets and education were include revisions to Vulnerate and procedures. Quarterly reinterviews will be conducted services or her delegate to fidentification of any actual or issues. Quarterly QA meetin 12/16/14. New changes related Vulnerable Adult Policy and were reviewed with the medicated to the policy and were trained as it relates to the respective roles and responsing regarding the policy and procedures.  Corrective action for this tage.	able Adult rievance I weekly log arterly with the and potential eview system ion will be roscribed ployee hire updated to ple adult policesident by social acilitate the potential goccurred or ted to the Procedure cal director.  I morning weekly IDT. ledical ng QA to practice are ministration their sibilities pedures on the responsible of the procedures on the responsible of the procedures on the responsible of the responsible o	y	
F 493	483.75(d)(1)-(2) GC	OVERNING BODY-FACILITY	F 4	completed on 12/18/14.		12/18/14	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED	
		245465	B. WING		11/24/2014	
	PROVIDER OR SUPPLIER	ME				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 493 SS=F	POLICIES/APPOIN  The facility must had designated person body, that is legally and implementing management and governing body aplicensed by the Stand responsible for facility  This REQUIREME by: Based on interview facility's governing oversight of management and safed to impleme abuse prohibition puthe health and safed deficient practice had residents currently  Findings include:  Refer to F224, as to ensure 5 of 8 reand R12) who made neglect, and/or mis provided follow up further staff abuse lack of identification	_	F 493	,	isible licies ration / is ase to :520 : the 12 on ts rts	
	residents from staf abuse, as well as t interventions to pre resulted in an imm	f neglect, mistreatment, and he lack of developing event further staff abuse, ediate jeopardy for all 36 residing in the facility who		to the state agency within the regulati requirements of the 5 working days. Internal facility investigation led to the termination of 2 employees. One employee was suspended pending fu	ion	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` ,	E SURVEY PLETED
		245465	B. WING		11/2	24/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 410 WEST MAIN STREET OSAKIS, MN 56360	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 493	and/or mistreatment Refer to F225, as administrator and all allegations of simistreatment for 5 R47 and R12) who maltreatment. The asystem was in postaff abuse, negler reported to the administration and were thorough Immediate Jeopar currently residing in Refer to F226, as abuse prevention implemented for 5 R47 and R12) who abuse, neglect, and facility failed to repand/or administration thorough investigation policy failed to addressure a resident when an investigation potential mistreatment affect all 36 resident facility.  Refer to F490, as adequately overse services related to implementation ar prohibition policies.	f potential staff abuse, neglect, nt.  the facility failed to report to the state agency, and investigate, taff abuse, neglect, and/ or of 8 residents (R52, R58, R44, or made allegations of staff e failure of the facility to ensure ace regarding all allegations of ct, and mistreatment were ministrator and state agency, nly investigated, resulted in an dy (IJ) for all 36 residents in the facility.  the facility failed to ensure the policy and procedure was of 8 residents (R52, R58, R44, or made allegations of staff dor mistreatment, and the port to the state agency (SA), tor, and did not complete a tion. In addition, the facility lives how the facility would would be kept free from abuse tion was taking place of ment. This had the potential to ints currently residing in the	F 4	training on resi-dent tranemployee required additeducation. The two empre-ceived further education return to work after the been completed. All about affected had care plans adjustments were required Mood/behavior focus changes in psychosocial concerns or effects from were noted.  Interviews conducted with all residents in the foundentify other potential neglect or mistreatment. Incident was immediated agency. The incident was investigated per Vulneral and procedures. Staff most was suspended and recitating on transfers priced work schedule. Safety Reserved and Procedure was revised to include the procedure was revised to include the procedure was alleged perpetrator. All lieged perpetrator. All lieged perpetrator.	ional dementia loyees that ion were allowed e education had we residents reviewed. No ed. arting was on all residents o monitor for any wellbeing. No the filed reports the all nursing staff ws conducted acility on 11/20/14 I cases of resident. During resident was reported. y reported to state is then ble Adult Policy ember involved eived additional or to her return to tisk assessments esidents and care sted.  Int initiated by Inerable Adult as reviewed and otection of ged act of include for suspension of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` '	SURVEY PLETED
		245465	B. WING			11/2	24/2014
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	11/2	-T/ <b>L</b> U1T
COMMU	NITY MEMORIAL HO	.RAC		4	10 WEST MAIN STREET		
COMMO	NITY MEMORIAL HO	VIVIE		С	SAKIS, MN 56360		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION (2		
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE
F 493	Continued From pa	age 103	F 4	93			
		ated to development,			received training and direction on h		
		nd evaluation of abuse			submit an alleged report of abuse to		
	prohibition policies	and procedures in the facility.			state agency. An in-service training		
	Refer to E520, as t	the facility quality assurance			trained consultant was conducted for vulnerable Adult and Abuse. This		
		identify and develop a plan of			education included reviewing the ha		
		concerns related to			copy of the updated Vulnerable Adu		
	development, impl	ementation, and evaluation of			Abuse and Prevention Plan, an in-c		
		policies and procedures in the			discussion on different types of abu		
	facility.				including examples of physical, ver		
	During intention of	n 11/04/14 of 1:01 n m the			and emotional abuse. The staff were educated on the new disciplinary	e also	
	During interview on 11/24/14, at 1:21 p.m. the governing board president (GP) stated the board				procedures during reports of allege	d	
	typically discussed disciplinary issues, such as				abuse. The new Abuse Protocol fol		
		eir monthly meetings. The			were also reviewed and the content		
		of the current issues related to			them were discussed at the inservi		
		policies and practices within the			director of nursing conducted 2 state		
		een aware of issues during the			meetings to review Vulnerable Adul		
		il 2014, also related to abuse of residents. The GP stated			and procedures. Policy and Proced Morning Standup, Weekly IDT, and		
		g they wanted addressed and			Quality Assurance were reviewed a		
		supportive of staff in doing their			revised to include added communic		
		stated they were unaware of			and review of incidents and Vulnera	able	
		rns with managerial staff or any			Adult trends. Grievances and or inc		
	-	this time related to facility			will be reviewed on a daily basis du	_	
	abuse accusations	s against stair.			the Morning Standup Meeting and with the IDT team which is led by the		
	The facility incorno	oration articles titled Community			facility administrator. All unresolved		
		Home at Osakis, Minnesota,			grievances will be reviewed quarter		
		d 8/12/1986, indicated the			the QA team for further review and	,	
		poration shall be to construct,			direction for resolution. An incident	_	
		e facilities for the care of the			was developed and put into place b		
		luding, but not limited to a			Director of Nursing, All incidents wi		
		ooarding home, and to any and for the accomplishment of this			reviewed during Morning Standup a then the incident will be placed on t		
					record. The log will be reviewed we		
		purpose. The articles also provided for a Board of Directors and indicated the business and			during IDT and quarterly with QA to		
		poration shall be managed by			assure that all incidents are fully		
	its Board of Directors.				investigated and complete. A new		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING			11/2	24/2014	
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 493	Continued From pa	age 104	F 4	193	grievance form was developed and onto place. Staff were educated by director of nursing on the location a proper use of the new facility grievatorms.  Staff education of Vulnerable Adult and Procedure will continue throug QAPI. During resident council on 12/18/14, a review of Vulnerable Ad Policy and Procedure and grievance procedure took place. All IDT week minutes will be reviewed quarterly QA team to review incidents and potential trends of abuse. Upon this review is revisions and/or staff education will implemented indicated via proscrib written action plan. New employee packets and education were update include revisions to Vulnerable adult and procedures. Quarterly resident interviews will be conducted by soot services or her delegate to facilitate identification of any actual or potentissues. Quarterly QA meeting occu 12/16/14. New changes related to the Vulnerable Adult Policy and Procedures were reviewed with the medical direction of the state survey was completed. All board members were educated on Vulnerable Adult Policy Procedures.  Board President attended quarterly meeting on 12/16/14. Moving forware member of the board will attend QA members of the board will attend QA members of the board will attend QA members will attend QA me	Policy h dult e ly log with the otential system ed hire ed to lt policy ial e the tial rred on he lure ector.  and a e y and  QA ard, one		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245465	B. WING		<del></del>	11/:	24/2014
	PROVIDER OR SUPPLIER	<b>NE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		BE	(X5) COMPLETION DATE
F 493 F 501 SS=F	DIRECTOR  The facility must de as medical director.	SIBILITIES OF MEDICAL signate a physician to serve	F 4		meetings for the next year.  A member of the IDT team will atter monthly board meetings.  The Governing Board has been invattend the Governing Board Leader Intensive workshop at the annual Lage Institute in February. At least of member of the board will attend this workshop.  Corrective action for this tag has becompleted on 12/18/14.	rited to rship eading one s	12/18/14
	This REQUIREMENty: Based on interview facility medical direct and collaboration with development, impleabuse prohibition profacility. This deficie	or is responsible for esident care policies; and the dical care in the facility.  In it is not met as evidenced or and document review, the ctor failed to provide guidance ith the facility staff related to ementation, and evaluation of colicies and procedures in the int practice had the potential to its currently residing in the			F501 It is the policy of Community Memore Home to designate a physician to sas medical director. The medical dis responsible for the implementation resident care policies; and the coordination of medical care in the In response to F224, F225 and F22 Vulnerable adult reports were filed state agency on residents #47 and 11/19/14 and reports filed on residents	serve director on of facility. 26: to the #12 on	

_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		.,
COMMU	NITY MEMORIAL HO	ME	410 WEST MAIN STREET OSAKIS, MN 56360				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 501	Refer to F224, as to ensure 5 of 8 result of ensure 5 of 8 result of the and R12) who made neglect, and/or mister provided follow upfurther staff abuse lack of identification residents, resulting residents from staff abuse, as well as the interventions to prevent to the animous residents currently remained at risk of and/or mistreatment. The administrator and sall allegations of stamps and R12) who maltreatment. The a system was in plastaff abuse, neglect reported to the administrator and were thorough limmediate Jeopard currently residing in Refer to F226, as the abuse prevention proposed for the administrator and R12) who abuse, neglect, and facility failed to represent thorough investigating policy failed to additional residual to additional residual to additional residual residual to additional residual res	he facility administration failed sidents (R52, R58, R44, R47 le allegations of staff abuse, streatment were protected and and resolution to prevent from occurring. The facility's nof staff mistreatment to in lack of protection for f neglect, mistreatment, and he lack of developing event further staff abuse, residing in the facility who potential staff abuse, neglect, nt.  The facility failed to report to the state agency, and investigate, aff abuse, neglect, and/ or of 8 residents (R52, R58, R44, made allegations of staff failure of the facility to ensure ace regarding all allegations of t, and mistreatment were ninistrator and state agency, ly investigated, resulted in an dy (IJ) for all 36 residents	F 5	501	#52, 58, and 44 on 11/21/14. All repwere thoroughly investigated and the results of those investigations were to the state agency within the regular requirements of the 5 working days Internal facility investigation led to the termination of 2 employees. One employee was suspended pending training on resident transfers and of employee required additional demonstration. The two employees that received further education were allowed to the received and care plans reviewed. In adjustments were required.  Mood/behavior focus charting was initiated and completed on all residents in the facility on 1 to identify other potential cases of reglect or mistreatment. During resinterviews, one incident was reported agency. The incident was then investigated per Vulnerable Adult Pand procedures. Staff member involved agency. The incident was then investigated per Vulnerable Adult Pand procedures. Staff member involved such all residents and plan changes were adjusted.	e filed ation s. he further ne entia sowed to lad ts No ents or any No eports ng staff ted 1/20/14 resident ed. to state rolicy olved ional urn to ments	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` '	E SURVEY PLETED
		245465	B. WING			11/2	24/2014
_	PROVIDER OR SUPPLIER	ме		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 501	potential mistreatm affect all 36 resider facility.  During interview on facility medical dire of the concerns of pidentified in the facility and had nursing (DON) earl concerns of lack of incidents of staff m failure to report incidents of staff m failure to report incidential administrator. The involved in develop the previous survey specific education vabuse. The MD stafacility on a quarter assurance meeting meetings unless he he needed to see, a patients he was the facility. MD stated reports, but could nunusual decrease in his review.  The undated facility Description indicate DON with resolution issues, and would predical care provided at all times. Addition medical director was and regulations affer acility and regulations affer acility and regulations affer acility.	on was taking place of ent. This had the potential to its currently residing in the 11/24/2014, at 11:03 a.m. the ctor (MD) stated he was aware previous abuse situations dity during the last survey in a spoken with the director of iter this week about the current investigation of alleged istreatment to residents and dents to the state agency and MD indicated he was not very ing the plan of correction for and had not done any with the facility staff related to ated he was typically in the lay basis for the quality and did not come in between a had a resident in the facility and currently MD had no a primary doctor for in the he reviewed resident incident not recall if he had seen an in incidents being forwarded for a Medical Director Job and the MD should assist the not any identified survey provide oversight to the ded throughout the care center as medical standards are met anally, the policy indicated the as the keep updated on rules are the medical staff are educated.	F	501	Zero Tolerance statement initiated I facility administrator. Vulnerable Ad Policy and Procedure was reviewed revised to include the protection of residents during an alleged act of abuse/neglect. Changes include immediate removal and/or suspens alleged perpetrator. All licensed state received training and direction on his submit an alleged report of abuse to state agency. An in-service training trained consultant was conducted from Vulnerable Adult and Abuse. The education included reviewing the hascopy of the updated Vulnerable Adult Abuse and Prevention Plan, an including examples of physical, very and emotional abuse. The staff were educated on the new disciplinary procedures during reports of allege abuse. The new Abuse Protocol followere also reviewed and the content them were discussed at the inserving director of nursing conducted 2 statement and procedures. Policy and Proced Morning Standup, Weekly IDT, and Quality Assurance were reviewed a revised to include added communicand review of incidents and Vulneral Adult trends. Grievances and or incident the Morning Standup Meeting and with the IDT team which is led by the facility administrator. All unresolved grievances will be reviewed quarter the QA team for further review and direction for resolution. An incident	dit di and di an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245465	B. WING		11	/24/2014	
	PROVIDER OR SUPPLIER  NITY MEMORIAL HOI	ме	STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O  X (EACH CORRECTIVE AC  CROSS-REFERENCED TO  DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 501	Continued From pa	ige 108	F 5	was developed and put Director of Nursing. All reviewed during Mornin then the incident will be record. The log will be record. Staff were edirector of nursing on the proper use of the new forms.  Staff education of Vulne and Procedure will cont QAPI. During resident of 12/18/14, a review of Vipolicy and Procedure a procedure took place. A minutes will be reviewed QA team to review inciderends of abuse. Upon the revisions and/or staff edimplemented indicated written action plan. New packets and education include revisions to Vulne and procedures. Quarted interviews will be conducted to the conduction of any activities and education of any activities. Quarterly QA modelication of any activities activities and the policy were reviewed with the The Job Description and Medical Director was record.	incidents will be and Standup and be placed on the log reviewed weekly by with QA to a re fully lete. A new veloped and put educated by the ne location and facility grievance be rable Adult Policy tinue through council on full and grievance and potential this review system ducation will be via proscribed of employee hire were updated to nerable adult policerly resident fucted by social to facilitate the ual or potential reeting occurred or a related to the and Procedure medical director. In Policy for the	y y	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245465	B. WING		11/:	24/2014
	PROVIDER OR SUPPLIER	ΛE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		
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F 501	The facility must mare resident in accorda standards and pract accurately document systematically organized.	LETE/ACCURATE/ACCESSIB  aintain clinical records on each nce with accepted professional tices that are complete; nted; readily accessible; and	F 5	updated.  The medical director reviewed all policy changes in all department a during QA meeting on 12/16/14. The Medical Directors Participar reviewing and acknowledgement compliance will be ongoing.  A schedule for policy review has be created with said policies being reprior to QA and discussed and act QA if appropriate. This procedube ongoing.  The Director of Nursing will be responsible for upkeep of the sch and distribution of the policies for The Administrator will be response compliance.  Corrective action for this tag was completed on 12/18/14.	ion in of policy seen viewed cepted re will sedule review.	12/18/14
	information to ident	ify the resident; a record of the ents; the plan of care and				

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-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		245465	B. WING _		11/2	24/2014
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		
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F 514	and progress notes  This REQUIREMED by:	the results of any ening conducted by the State; s.	F 51			
	facility failed to mai records for 1 of 1 re pressure ulcers and Findings include:  R21's record include Assessment/Monito which identified the pressure ulcers. The description identified [with] a dark purple reddened ring. Skir wounds were noted	led a Wound bring form dated 10/20/14, be presence of two left heel he wound appearance and, "Red discolored skin 4x4 confilled blister inside the around site blanches." The left to be stage one.		Comprehensive Skin Assessment Nutrition Risk Assessment were completed on R21 and added interventions were placed in care p weight loss and skin integrity. A co note was placed in resident record accurately stage the pressure ulce  There are no other residents residi facility with pressure ulcers. All res with known skin issues had a revie recent wound assessments to assi the records were accurately docum	olan for rrection to r. ng in idents w of ure that	
	included the followi on how to stage pre- · A stage one pre- included, "Intact sk redness of a localiz prominence." · A stage two pre- included, "May also open/ruptured seru · A suspected de as a, "Purple or ma discolored intact sk damage of underlyi and/or sheer." · An Unstageabl	essure ulcer description in with non-blanchable ed area usually over a bony essure ulcer description present as an intact or		Wound Policy and Procedure was and reviewed with the quarterly QA Education was provided to all licen staff related to the importance of a documentation.  Wound documentation will be audi weekly through wound rounds by the DON. The DON will stage all wound all licensed staff have received appropriate education and wound sinstructions. The results will be revieweekly with IDT and quarterly with team.	team. sed ccurate ted ne ds until staging iewed QA	

Facility ID: 00109

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		245465	B. WING		11	/24/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 410 WEST MAIN STREET OSAKIS, MN 56360		, <b>-</b> 1, - <b>-</b> 1	
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F 514	some parts of the vundermining and to undermining and to undermining and to R21's Wound/Asset 10/27/14, noted the left heel with a des discolored skin is 2 purple filled blister pressure ulcers we one. R21's Wound/Asset 11/3/14, noted the heel with a descript discolored skin corrintact." The pressure documented as a sR21's Wound/Asset 11/6/14, noted the heel with a descript discolored skin corrintact." The docum stage of the pressure R21's Wound/Asset 11/11/14, noted the heel with a descript discolored skin corrintact." The pressure R21's Wound/Asset 11/14/14, noted the heel with a descript discolored skin corrintact. The pressure R21's Wound/Asset 11/14/14, noted the heel with a descript discolored skin corrintact. The pressure R21's Wound/Asset 11/14/14, noted the	or eschar may be present on wound bed. Often include unneling."  essment Monitoring form dated two pressure ulcers on the cription which read, "Red ex2 cm [centimeters] with dark inside reddened ring." The cre documented as a stage essment Monitoring form dated two pressure ulcers on the left tion which read, "Red estinues with dark filled blister re ulcers were again stage one. Essment Monitoring form dated two pressure ulcers on the left tion which read, "Red essment Monitoring form dated two pressure ulcers on the left tion which read, "Red estinues with dark filled blister entation did not include any	F 51	,			
	intact." The pressu "Unstageable." R21's Wound/Asse 11/17/14, noted the left heel with a des discolored skin cor	essment Monitoring form dated etwo pressure ulcers on the cription which read, "Red ntinues with dark filled blister re ulcers were documented as					

_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245465	B. WING		11	/24/2014	
	PROVIDER OR SUPPLIER	ЛE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		, <b>= 1</b> , <b>= 0</b> .	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
	"Unstageable." During interview on registered nurse (R responsible for com Assessment/Monito R21's wound forms stated all the asses R21's left heel pres stage one, had bee appeared from the stage two. During interview on consulting dietician contacted after the pressure ulcers bed stage one, and typic warrant nutritional i stated only if the pressure undinterventions be red was unaware R21's been staged incorre R21 had pressure useditional nutritional been put into place The facility policy tit Record Policy States a medical record was responsible."	11/20/14, at 9:26 a.m. N)-D stated the RNs were apleting the Wound bring forms. Upon review of and descriptions, RN-D sments which had noted sure ulcers to have been at a n staged incorrectly, and description to be at least a  11/20/14, at 1:41 p.m. (D)-A stated she had not been development of R21's cause they were noted to be cally stage one ulcers did not interventions for healing. D-A essure ulcers were a stage dimmediate nutritional quired to be put into place. D-A is left heel pressure ulcers had ectly, and if D-A had known ulcers worse then a stage one, if interventions would have to promote healing. Ited Purpose of the Medical ement dated 4/16/13, indicated build be maintained to provide rate resident information for	F 5			12/18/14	
	assurance committ	tain a quality assessment and ee consisting of the director of physician designated by the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245465	B. WING			11/2	24/2014
	PROVIDER OR SUPPLIER	мE		4	TREET ADDRESS, CITY, STATE, ZIP CODE  10 WEST MAIN STREET  DSAKIS, MN 56360		
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F 520	facility; and at least facility's staff.  The quality assess committee meets a issues with respect and assurance acti develops and impleaction to correct ide.  A State or the Seci disclosure of the reexcept insofar as a compliance of such requirements of this Good faith attempts and correct quality a basis for sanction.  This REQUIREMED by: Based on interview.	and assurance to least quarterly to identify to which quality assessment wities are necessary; and ements appropriate plans of entified quality deficiencies.  Tetary may not require cords of such committee uch disclosure is related to the accommittee with the section.	F 5	200	F520 It is the policy of Community Memor	rial	
	identify and develop concerns related to implementation, an prohibition policies This deficient pract all 36 residents cur	a plan of action to address			Home to maintain a quality assessn and assurance commit-tee consistir the director of nursing services, a physician designated by the facility; least 3 other members of the facility staff. In response to F224, F225 an F226: Vulnerable adult reports were	nent ng of and at sold e filed	
	failed to ensure 5 o R47 and R12) who abuse, neglect, and	ne facility failed administration f 8 residents (R52, R58, R44, made allegations of staff d/or mistreatment were ded follow up and resolution to			to the state agency on residents #4: #12 on 11/19/14 and reports filed or residents #52, 58, and 44 on 11/21/ reports were thoroughly investigated the results of those investigations w filed to the state agency within the regulation requirements of the 5 wo	n 14. All d and vere	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	` '	E SURVEY PLETED
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COMMU	NITY MEMORIAL HO	ME				
				OSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- ( (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 520	facility's lack of ide to residents, result residents from staf abuse, as well as t interventions to prevented in an immeresidents currently remained at risk of and/or mistreatment. Refer to F225, as t administrator and sall allegations of st mistreatment for 5 R47 and R12) who maltreatment. The a system was in playstem was in playstem to the adrand were thorough Immediate Jeopard currently residing in Refer to F226, as the abuse prevention primplemented for 5 R47 and R12) who abuse, neglect, and facility failed to repand/or administration thorough investigation policy failed to add ensure a resident when an investigation.	iff abuse from occurring. The intification of staff mistreatment ing in lack of protection for fineglect, mistreatment, and he lack of developing event further staff abuse, ediate jeopardy for all 36 residing in the facility who potential staff abuse, neglect, int.  The facility failed to report to the state agency, and investigate, aff abuse, neglect, and/ or of 8 residents (R52, R58, R44, made allegations of staff afailure of the facility to ensure acc regarding all allegations of att, and mistreatment were ministrator and state agency, ly investigated, resulted in an analy (IJ) for all 36 residents in the facility.  The facility failed to ensure the colicy and procedure was of 8 residents (R52, R58, R44, made allegations of staff dor mistreatment, and the ort to the state agency (SA), or, and did not complete a tion. In addition, the facility ress how the facility would would be kept free from abuse ion was taking place of	F 5	days. Internal facility investigate the termination of 2 employees employee was suspended penetraining on resident transfers a employee required additional deducation. The two em-ployees received further education were return to work after the education been completed. All above resident adjustments were required. Mood/behavior focus charting initiated and completed on all r #52, 58, 44, 47 and 12 to monichanges in psychosocial wellbed concerns or effects from the fill were noted.  Interviews conducted with all non 11/19/14 and interviews conwith all residents in the facility of to identify other potential cases neglect or mistreatment. During interviews, one incident was relincident was immediately report agency. The incident was then investigated per Vulnerable Adand procedures. Staff member was suspended and received a training on transfers prior to he work schedule. Safety Risk asswere completed on all resident plan changes were adjusted.  Zero Tolerance statement initia	One ding further and one ementia that e allowed to on had dents ed. No vas esidents or for any ing. No ed reports ursing staff ducted in 11/20/14 of resident ported. It ed to state all Policy involved dditional return to essments and care ited by	
		nent. This had the potential to nts currently residing in the		facility administrator. Vulnerabl Policy and Procedure was revised to include the protectio residents during an alleged act	wed and of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		NSTRUCTION	` '	E SURVEY PLETED
		245465	B. WING			11/3	24/2014
NAME OF I	PROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE	1 11/2	24/2014
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F 520	During interview or registered nurse (I was a quality assured unaware of any cur During interview or stated she was away facility but was not projects or concern During interview or licensed practical on the sure if the facil During interview or administrator state on injuries of unknown recognize bruising them. Reporting any potential abuse has the QA committee department direct committee to ensure covered.  The facility policy dated 11/17/08, incommittee include physical, psycholo the residents, and assist departments resident services as	n 11/21/14, at 12:08 p.m. RN)-A stated she thought there rance (QA) committee, but was rrent QA projects. n 11/21/14, at 12:17 p.m. RN-C rare of a QA committee in the aware of any current QA ns they were working on. n 11/21/14, at 12:22 p.m. nurse (LPN)-A stated she was ity had a QA committee. n 11/21/14, at 1:47 p.m. the ad the facility had been focused own origin and assisting staff to injuries and how to prevent and recognition of other types of d not been a specific focus of a The administrator stated all ors were members of the QA are all needs of the facility were titled Quality Assurance Plan dicated the objectives of the QA d maintaining or improving the gical, and social well-being of the QA committee was to so to continuously improve and care by identifying agh the use of internal	F 5	abus immalled reconstant state on education ed	use/neglect. Changes include mediate removal and/or suspense ged perpetrator. All licensed state ived training and direction on homit an alleged report of abuse in the agency. An in-service training ined consultant was conducted in Vulnerable Adult and Abuse. The ucation included reviewing the hoy of the updated Vulnerable Adults and Prevention Plan, an incussion on different types of abuse and Prevention Plan, an incussion on different types of abuse and examples of physical, very demotional abuse. The staff we ucated on the new disciplinary occlures during reports of allegence. The new Abuse Protocol for also reviewed and the content were discussed at the inserving ector of nursing conducted 2 states are to include added communicated to include	aff now to to the g by a for staff is ard ult depth use bal, re also ed lders its of ce. The fit policy dures of d and cation able cidents uring weekly ne d rly with log by the ill be and the log	

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		245465	B. WING		_	11/24/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	
сомми	NITY MEMORIAL HO	ME		410 WEST MAIN STREET		
				OSAKIS, MN 56360		
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F 520	Continued From page 1	age 116	F 5	during IDT and quait assure that all incide investigated and congrievance form was onto place. Staff we director of nursing or proper use of the net forms.  Staff education of V and Procedure will of QAPI. During resides 12/18/14, a review of Policy and Procedure procedure took place minutes will be review of Ateam to review it trends of abuse. Up revisions and/or state implemented indicate written action plan. It packets and educate include revisions to and procedures. Que interviews will be conservices or her delected identification of any issues. Quarterly Questions and procedures of the procedure of the pro	ents are fully implete. A new developed and pure educated by the on the location and ew facility grievance fullnerable Adult Potential and grievance fee. All IDT weekly I lewed quarterly with incidents and potential and proscribed New employee hire ion were updated a vulnerable adult pure to facilitate the actual or potential and procedure and potential and procedure and procedure and procedure and procedure and procedure and procedures will	e d d d d d d d d d d d d d d d d d d d

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	(X3) DAT COM	E SURVEY IPLETED
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	PROVIDER OR SUPPLIER	ΛE		STREET ADDRESS, CITY, STATE, ZIP COI 410 WEST MAIN STREET OSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 520	Continued From pa	ge 117	F 52	-A Board member will attend meetings for the next year.  The corrective action for this completed on 12/18/14		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:** 

(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 (X3) DATE SURVEY COMPLETED

245465

B. WING

11/19/2014

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION IN THE FACILITY'S POC WILL SERVE AS YOU ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIPAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE UPON RECEIPT OF AN ACCEPTABLE POONSITE REVISIT OF YOUR FACILITY MAY	N) TAG  K 0  DUR  HE  IRST  E  CE.  DC, AN	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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ONSITE REVISIT OF YOUR FACILITY MA			
CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION			
A Life Safety Code Survey was conducted to Minnesota Department of Public Safety, Stafire Marshal Division. At the time of this surthe 1963 and 1977 sections of Community Memorial Home were found to be not in substantial compliance with the requirement participation in Medicare/Medicaid at 42 CF Subpart 483.70(a), Life Safety from Fire, and 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care	ate rvey, nts for FR, nd the		
PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:		EPOC	
HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or			

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

**Electronically Signed** 

12/23/2014

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

Facility ID: 00109

PRINTED: 12/31/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 11/19/2014 245465 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **410 WEST MAIN STREET COMMUNITY MEMORIAL HOME OSAKIS, MN 56360** (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 | Continued From page 1 K 000 By e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This facility was surveyed as two separate buildings. Community Memorial Home is a 2 story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1963, is one story and was determined to be of Type II(000) construction. In 1977, a one story, Type II(000), expansion to the dining room was added. Because the original 1963 building and the 1977 addition meet the construction type allowed for existing buildings, these buildings were surveyed as one existing building. The 2 story 2008 Wellness Center addition was surveyed as new construction. The building is fully fire sprinklered throughout. The facility has a fire alarm system that includes smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 36 at the time of the survey.

Facility ID: 00109

PRINTED: 12/31/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 11/19/2014 245465 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 410 WEST MAIN STREET **COMMUNITY MEMORIAL HOME** OSAKIS, MN 56360 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 | Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: 12/18/14 K 067 NFPA 101 LIFE SAFETY CODE STANDARD K 067 SS=F Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's 19.5.2.1, 9.2, NFPA 90A, specifications. 19.5.2.2 This STANDARD is not met as evidenced by: We are again requesting an annual Based on observations and an interview, it was waiver for K 067. revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation... Findings include: During the facility tour between 9:00 AM and 12:00 PM on 11/19/14, an interview with the Facility Administrator (DC), a review of documentation and observations revealed that the HVAC systems for all wings of the 1963 and 1977 additions have ducted air supply to the corridors and no return or exhaust from the corridors. There is no supply or return in the resident rooms, which all have bathroom exhaust fans that are constantly exhausting to the outside. This situation is using the corridors as a supply

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COMI	SURVEY PLETED
		245465	B. WING			11/1	19/2014
	PROVIDER OR SUPPLIER	ME.		41	REET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET SAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 067	Continued From pa plenum. This was confirmed Environmental Sen	by the Director of	K	067			
	An annual waiver h	as been previously granted.					
	÷ Ř						

### Sheehan, Pat (DPS)

From:

Sheehan, Pat (DPS)

Sent:

Monday, December 29, 2014 10:26 AM

To:

rochi\_lsc@cms.hhs.gov

Cc:

james.a.anderson@state.mn.us; dcarlson@galeonmn.com; Kappenman, Angela (DPS); Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); marian.whitney@state.mn.us; Meath,

Mark (MDH); Zwart, Benjamin (MDH)

Subject:

Community Memorial Home (245465) K67 Annual Waiver Request - Previously

Approved - No Change

This is to notify you that Community Memorial Home is again requesting an annual waiver for K67, corridors as a plenum. The exit date was 11-19-14.

I am recommending that CMS approve this waiver request.

### Patrick Sheehan, Fire Safety Supervisor

Office: 651-201-7205 Cell: 651-470-4416 Health Care & Corrections Fire Inspections

Minnesota State Fire Marshal Division Est. 1905 445 Minnesota St., Suite 145, St Paul, MN 55101-5145

FAX: 651-215-0525 Web: fire.state.mn.us

# Name of Facility

Community Memorial Home at Osakis, MN Inc.

# PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet For each item of the Life Safety code recommended for waiver, list the survey report form item provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

A continuing waiver is being requested for K067 for the following reasons:

A. An extreme financial hardship on Community Memorial Home (CMH) will result from compliance because: compliance with NFPA 90A will cost between \$446,120 and \$579,299. Funding is not available under CMH is completely protected by a supervised sprinkler system installed in accordance with NFPA 13; HVAC ventilation fans automatically shut down upon fire alarm activation or the detection of smoke; Resident sleeping rooms are all equipped with single station battery operated smoke detectors; Asbestos abatement required during installation would cost between \$59,483 and 81,900; and The electrical system at CMH would need to be modified at a cost that may exceed \$42,000; If this waiver is approved, the safety of building occupants will not be compromised because: Walls, floors, ceilings and vertical openings at CMH already resist the passage of smoke; 1. Estimates (5-14-14 attached) that were confirmed on 12-04-14 (attached) show that The property of CMH is smoke and tobacco free with signs posted to that effect; Non-complying systems are allowed to be used under LSC(00), 9.2.1. JUSTIFICATION CMH was built under Type II construction standards; current reimbursement rules; œ. PROVISION NUMBER(S) CMH does not comply the corridors are used with LSC (00) Section 1999 Edition because (HVAC) equipment at and Air Conditioning Heating, Ventilation 9.2 and NFPA 90A. as a plenum. K067

lavid E. Carlson, Administrator Requested by:

The local fire department is located 6 blocks away and will respond to an alarm in less than 10 mins;

All CMH corridors are equipped with a compliant UL listed smoke detection system;

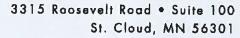
CMH has an approved fire safety plan and is compliant with all other fire safety requirements; and

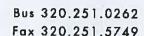
A continuing walver has been approved annually in the past for Community Memorial Home.

Surveyor (Signature)	₽		Office		Date	
Fire Authority Official (Signature)	Title	Fire Safety	Office	Stato Fira Marshel	Date (2 -39-14	

Form CMS-2786R (03/04) Previous Versions Obsolete

Page 26





www.ramorton.com



**December 4, 2014** 

Dave Carlson, Administrator Galeon 410 West Main Street Osakis, MN 56360

Dear Dave:

Per our conversation today, costs for complying with NFPA 90A shown in the Preliminary Master Budget that I provided to you on 5-14-14 have not changed. Please consider the high and low ranges provided in that budget to be our current estimate of cost. Thank you.

Sincerely:

Preston Euerle President/CEO





PRELIMINARY MASTER BUDGET Galeon - Community Memorial Home PREPARED: 5/14/2014

3315 Roosevelt Road, Ste. 100 St. Cloud MN 56301

Bus. (320) 251-0262 Fax: (320) 251-5749

Low Range 24,000 S.F. High Range 24,000 S.F.

DOLLARS

DOLLAR\$

I. LAND	SUBTOTAL LAND	\$		\$ -	
II. CONSTRUCTION COSTS			 2111434110-11		
GENERAL CONDITIONS		\$ 26,523	\$ 1.11	\$ 32,448	\$ 1.35
INTERIOR FINISHES / DEMO	0	\$ 19,096	\$ 0.80	\$ 29,203	\$ 1.22
MECHANICAL		\$ 203,693	\$ 8.49	\$ 259,584	\$ 10.82
FIRE SPRINKLER		\$ 5,305	\$ 0.22	\$ 10,816	\$ 0.45
ELECTRICAL	14	\$ 37,132	\$ 1.55	\$ 43,264	\$ 1.80
CONTINGENCY	9	\$ 30,000	\$ 1.25	\$ 38,000	\$ 1.58
SUBTOTAL CONS	TRUCTION COSTS	\$ 321,748	\$ 13.41	\$ 413,315	\$ 17.22
III. SOFT COSTS					
FEES / PERMITS / PRINTING	3	\$ 64,890	\$ 2.70	\$ 84,084	\$ 3.50
OTHER		\$ 	\$ 	\$ 	\$ 
SUBTO	OTAL SOFT COSTS	\$ 64,890	\$ 2.70	\$ 84,084	\$ 3.50
IV. OWNER ITEMS	8				
FURNITURE/FIXTURES/EQU	JIPMENT	\$ -		\$ -	
OTHER - ASBESTOS ABATE	MENT	\$ 59,483	\$ 2.48	\$ 81,900	\$ 3.41
SUBTOTAL OW	NER ITEMS COSTS	\$ 59,483	\$ 2.48	\$ 81,900	\$ 3.41
V. TOTAL PROJECT COST	E 1	\$ 446,120	\$ 18.59	\$ 579,299	\$ 24.14

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

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

F5465025

(X2) MULTIPLE CONSTRUCTION

PRINTED: 12/31/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 02 B. WING 11/19/2014 245465 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 410 WEST MAIN STREET **COMMUNITY MEMORIAL HOME OSAKIS, MN 56360** (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, the 2008 Wellness Center Addition of Community Memorial Home 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. Community Memorial Home was surveyed as two separate buildings. The 2008 Wellness Center addition is a 2-story building with no basement, and was determined to be of Type II (111) construction. The building is fully fire sprinklered throughout and has a fire alarm system that includes smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The requirement at 42 CFR, Subpart 483.70(a) is MET. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE TITLE

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.

12/23/2014

**Electronically Signed** 



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted December 10, 2014

Mr. David Carlson, Administrator Community Memorial Home 410 West Main Street Osakis, Minnesota 56360

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5465025

Dear Mr. Carlson:

The above facility was surveyed on November 17, 2014 through November 24, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Community Memorial Home December 10, 2014 Page 2

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

(X6) DATE

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00109	B. WING		11/2	4/2014	
NAME OF I	PROVIDER OR SUPPLIER		DDESS CITY O	STATE, ZIP CODE	11/2	4/2014	
		410 WFS	Γ MAIN STRI				
COMMU	NITY MEMORIAL HON	OSAKIS,	MN 56360				
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2 000	Initial Comments		2 000				
	*****ATTE	NTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.					
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was					
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.					
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/infe licensing orders are					

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 12/20/14

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
сомми	INITY MEMORIAL HOM	ΛF	T MAIN STRE MN 56360	ET		
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2 000	Department of Hea you electronically, is necessary for Sta enter the word "corrected. You must then State licensure procompletion date, the corrected prior to el Minnesota Department on November 17, 2014, surveyors of the above provider orders are issued. electronic plan of correviewed these ordered they will be completed. Minnesota Department of State Licensing federal software. Ta assigned to Minnesota Nursing Homes.  The assigned tag in column entitled "ID statute/rule out of completed in the statement of the statement of the statement of the statement of the Suggested of th	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the ment of Health.  18, 19, 20, 21, 22, 23 and 24th this Department's staff, visited and the following correction Please indicate in your prection that you have ers, and identify the date when ted.  Inent of Health is documenting Correction Orders using ag numbers have been tota state statutes/rules for umber appears in the far left of Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the nis column also includes the n violation of the state statute are in the surveyors findings wethod of Correction and rection.  IRD THE HEADING OF THE				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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2 255	Assurance Commit A nursing home mu assessment and as of the administrator services, the medic designated by the n three other membe representing discipl resident care. The assurance committ respect to which qu necessary and deve appropriate plans o quality deficiencies address, at a minim reporting, infection pharmacy services.	ast maintain a quality surance committee consisting of the director of nursing all director or other physician nedical director, and at least rs of the nursing home's staff, lines directly involved in quality assessment and ee must identify issues with ality assurance activities are elop and implement f action to correct identified. The committee must num, incident and accident control, and medications and	2 255			12/20/14
	Based on interview facility quality assur identify and develor concerns related to implementation, an prohibition policies This deficient practi	and document review, the rance committee failed to a plan of action to address development, devaluation of abuse and procedures in the facility ice had the potential to affect rently residing in the facility.		Corrected		

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) D  A. BUILDING: (X3) D	(X3) DATE SURVEY COMPLETED	
00109 B. WING 1	1/24/2014	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
COMMUNITY MEMORIAL HOME  410 WEST MAIN STREET  OSAKIS, MN 56360		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Refer to F224, as the facility failed administration failed to ensure 5 of 8 residents (R52, R58, R44, R47 and R12) who made allegations of staff abuse, neglect, and/or mistreatment were protected and provided follow up and resolution to prevent further staff abuse from occurring. The facility's lack of identification of staff mistreatment to residents, resulting in lack of protection for residents from staff neglect, mistreatment, and abuse, as well as the lack of developing interventions to prevent further staff abuse, resulted in an immediate jeopardy for all 36 residents currently residing in the facility who remained at risk of potential staff abuse, neglect, and/or mistreatment.  Refer to F225, as the facility failed to report to the administrator and state agency, and investigate, all allegations of staff abuse, neglect, and/or mistreatment for 5 of 8 residents (R52, R58, R44, R47 and R12) who made allegations of staff maltreatment. The failure of the facility to ensure a system was in place regarding all allegations of staff abuse, neglect, and mistreatment were reported to the administrator and state agency, and were thoroughly investigated, resulted in an Immediate Jeopardy (IJ) for all 36 residents (C52, R58, R44, R47 and R12) who made allegations of staff abuse, neglect, and mistreatment were reported to the administrator and state agency, and were thoroughly investigated, resulted in an Immediate Jeopardy (IJ) for all 36 residents currently residing in the facility failed to ensure the abuse prevention policy and procedure was implemented for 5 of 8 residents (R52, R58, R44, R47 and R12) who made allegations of staff abuse, neglect, and/or mistreatment, and the facility failed to report to the state agency (SA), and/or administrator, and did not complete a thorough investigation. In addition, the facility policy failed to address how the facility would ensure a resident would be kept free from abuse		

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00109	B. WING	<del></del>	11/2	24/2014
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
СОММИ	NITY MEMORIAL HON	1F	MN 56360	<b>-</b> E1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 255	potential mistreatmaffect all 36 resident affect all 36 resident facility.  During interview on registered nurse (Rwas a quality assurd unaware of any curn During interview on stated she was awafacility but was not a projects or concern During interview on licensed practical not sure if the facility During interview on administrator stated on injuries of unknown recognize bruising in them. Reporting an potential abuse had the QA committee. department director committee to ensur covered.  The facility policy to dated 11/17/08, indicommittee included physical, psycholog the residents, and to assist departments resident services are	ent. This had the potential to ts currently residing in the  11/21/14, at 12:08 p.m. N)-A stated she thought there ance (QA) committee, but was rent QA projects. 11/21/14, at 12:17 p.m. RN-C are of a QA committee in the aware of any current QA is they were working on. 11/21/14, at 12:22 p.m. urse (LPN)-A stated she was y had a QA committee. 11/21/14, at 1:47 p.m. the if the facility had been focused own origin and assisting staff to injuries and how to prevent did recognition of other types of a not been a specific focus of the administrator stated all is were members of the QA in all needs of the facility were ted Quality Assurance Plan cated the objectives of the QA maintaining or improving the ical, and social well-being of the QA committee was to to continuously improve and care by identifying the use of internal				
		of Correction: The work with the DON or director, and governing body to				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/0	4/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	11/2	4/2014
	NITY MEMORIAL HON	410 WEST	MAIN STRI			
COMMO		OSAKIS, I	MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 255	and develop improvadministrator and of to ensure resident of resident mistreat agency and investig	procedures, identify issues vement plans. The ir designee could audit cares needs are met, and allegations ment are reported to the state	2 255			
2 570	Plan of Care; Revision care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within the comprehensive by part 4658.0400,  This MN Requirements:	A comprehensive plan of wed and revised by an m that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, practicable, with the resident, the resident's legal representative at least a seven days of the revision of resident assessment required subpart 3, item B.	2 570			12/20/14
	Based on interview failed to revise the residents (R21) with Findings include:  R21's admission M 9/20/14, identified Fimpaired and was treating.	and record review, the facility plan of care for 1 of 3 in significant weight loss.  Inimum Data Set (MDS) dated R21 was severely cognitively otally dependent on staff for sed 11/17/14, identified R21		Corrected		

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wiirineso	ta Department of He	ailli				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE S COMPL	
		00109	B. WING		11/24	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS. CITY. S	STATE, ZIP CODE		
		410 WEST	MAIN STRE			
COMMU	NITY MEMORIAL HON	Λ <b>Ε</b>	MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 6	2 570			
	modified texture die The goal was to ma directed to monitor plan did not identify weight loss. R21's nutritional ris 9/23/14, identified F	e with eating, received a et, and was lactose intolerant. Aintain weight and staff were food and fluid intake. The care R21 had sustained any k assessment completed R21's weight was 159 pounds, pureed texture diet, was				
	unable to make me was totally fed by st attempt to feed him	al/food preferences known, taff, and did not make any self				
	<ul> <li>9/17/14 159 p</li> <li>10/1/14 156.5</li> <li>10/8/14 156 p</li> <li>10/15/14 151.5</li> <li>10/22/14 149.5</li> <li>a 6% decrease frommonth prior</li> <li>10/29/14 148.5</li> <li>10.5 pounds since a</li> <li>11/12/14 148 po</li> <li>11/19/14 146 po</li> </ul>	pounds ounds pounds pounds which was flagged as n 159 pounds less than a pounds which was a loss of admission				
	manager (DM)-A st would trigger a notified resident's weight dries stated R21 had first 10/22/14, with a lost would complete the care plan, and conficare plan had not be	11/20/14, at 9:14 a.m. dietary ated the computer system fication for her when a opped 5% or greater. DM-A triggered for weight loss on s of 6%. DM-A stated she nutritional part of a resident's irmed as of 11/17/14, R21's een updated to reflect lated to the weight loss.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED	
		00109	B. WING		11/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COMMU	NITY MEMORIAL HO	ИE	TMAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 570	Review of the facility Weight Loss dated would be considered loss if they had green one month or great three months. The gave direction to repertinent information of the careplan Process I indicated information all disciplines updated for each detrained to write care reviewed monthly, of the constant of the care for	by policy titled Significant 10/12/10, indicated residents and to have significant weight later than 5% weight loss in er than 7.5% weight loss in procedure within the policy view the care plan for in.  If Care Conferences and last updated on 1/20/10, on for the care plan may come and will be written and lepartment by staff members are plans. Care plans would be quarterly, and as needed.  If Correction: The DON or with the interdisciplinary lator, and nurse managers to ments for accuracy, create a plans, review and revise the plan updating, and then DON or designee could also lesident records to determine if sed on comprehensive led in a timely fashion, and	2 570			
2 625	MN Rule 4658.0450 Contents; In Gener	O Subp. 1 A-P Clinical Record al	2 625			12/20/14
	record, including n	neral. Each resident's clinical ursing notes, must include: n of the resident at the time of				

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  410 WEST MAIN STREET  OSAKIS, MN 56360   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE  TAGE  COMMUNITY OR LSC IDENTIFYING INFORMATION)  2 625  Continued From page 8  admission;  B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item 1;  C. the resident's height and weight, according to part 4658.0520, subpart 2, item J;  D. the resident's general condition, actions, and attitudes;  E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel;  F. significant observations on, for example,	STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
COMMUNITY MEMORIAL HOME  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 625  Continued From page 8 admission;  B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item 1;  C. the resident's height and weight, according to part 4658.0520, subpart 2, item J;  D. the resident's general condition, actions, and attitudes;  E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel;			00109	B. WING		11/2	4/2014
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 625  Continued From page 8  admission;  B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I;  C. the resident's height and weight, according to part 4658.0520, subpart 2, item J;  D. the resident's general condition, actions, and attitudes;  E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel;	NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 625 Continued From page 8 admission;  B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item 1;  C. the resident's height and weight, according to part 4658.0520, subpart 2, item 3;  D. the resident's general condition, actions, and attitudes;  E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel;	0014141	NITY MEMORIAL LIGH	410 WEST	MAIN STRI	EET		
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 625  Continued From page 8  admission;  B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I;  C. the resident's height and weight, according to part 4658.0520, subpart 2, item J;  D. the resident's general condition, actions, and attitudes;  E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel;	СОММО	NITY MEMORIAL HOP	OSAKIS, I	MN 56360			
admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel;	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	.D BE	COMPLETE
B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel;	2 625	Continued From pa	ge 8	2 625			
behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent	2 023	admission; B. temperature pressure, according subpart 2, item C. the resident according to part 4 D. the resident and attitudes; E. observations interventions provior responsible for care of the residential communication persons who administ the signature of persons who administ the signature of persons who administ the months prior in part 4658.08 I. reports of lab J. dates and tindressings; K. dates and tindressings; K. dates and tindressings; K. dates and tindressings; K. dates and tindressings; Comprehensive pla N. any orders of comprehensive pla n. any change habits or appetite; O. pertinent factoresident's general compressions of the resident's general compressions of the resident of t	e, pulse, respiration, and blood of to part 4658.0520, I; I; sheight and weight, 658.0520, subpart 2, item J; Is general condition, actions, Is, assessments, and led by all disciplines resident, with the exception of unications with nnel; beervations on, for example, in, adjustment to the judgment, or moods; quantity of dosage, and ration of all medications, and if the nurse or authorized histered the medication; in tuberculin test within the to admission, as described 10; coratory examinations; mes of all treatments and the sof visits by all licensed oners; cor instructions relative to the in of care; in the resident's sleeping corors regarding changes in the conditions; and initial comprehensive	2 023			

Minnesota Department of Health

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-	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00109	B. WING		11/2	4/2014
		OTDEET AD		TATE TIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		ļ
COMMU	NITY MEMORIAL HON	ΛF	MAIN STR	EET		
		OSAKIS, I	MN 56360			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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ma		,	i, KG	DEFICIENCY)		
0.605	Canting and Every no		2 625			
2 625	Continued From pa	ge 9	2 625			
	part 4658.0400.					
	•					
	·	ent is not met as evidenced				
	by:					
		and document review, the		Corrected		
		ntain complete and accurate				
		esidents (R21) reviewed for				
	pressure ulcers and	a weight ioss.				
	Findings include:					
	R21's record includ	ed a Wound				
		oring form dated 10/20/14,				
		e presence of two left heel				
		e wound appearance				
		d, "Red discolored skin 4x4 c				
		filled blister inside the				
		around site blanches." The				
	wounds were noted	l to be stage one.				
		ment/Monitoring form				
		ng definitions instructing staff				
	on how to stage pre					
		essure ulcer description				
		n with non-blanchable				
		ed area usually over a bony				
	prominence."	soure ulear description				
		essure ulcer description present as an intact or				
	open/ruptured seru					
		ep tissue injury was described				
		roon localized are of				
		in or blood-filled blister due to				
		ng soft tissue from pressure				
	and/or sheer."	9				
		e pressure ulcer was,"Full				
		s with exposed bone, tendon				
		or eschar may be present on				
		ound bed. Often include				

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Millinesc	ita Department of He	eaim				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<del></del>	COMPLETED	
		00109	B. WING		11/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDESS CITY S	STATE, ZIP CODE		
INAIVIL OI I	THOUBER ON SOLT EIER		Γ MAIN STRI			
COMMU	NITY MEMORIAL HON	ME	MN 56360			
	0					
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
2 625	Continued From pa	ge 10	2 625			
	undermining and tu	nneling."				
	R21's Wound/Asse	ssment Monitoring form dated				
		two pressure ulcers on the				
		cription which read, "Red				
		x2 cm [centimeters] with dark				
		nside reddened ring." The				
	· ·	re documented as a stage				
	one.	coment Manitaring form dated				
		ssment Monitoring form dated wo pressure ulcers on the left				
		ion which read, "Red				
		tinues with dark filled blister				
		re ulcers were again				
	documented as a s					
	R21's Wound/Asse	ssment Monitoring form dated				
		wo pressure ulcers on the left				
		ion which read, "Red				
		tinues with dark filled blister				
		entation did not include any				
	stage of the pressu	ssment Monitoring form dated				
		two pressure ulcers on the left				
		ion which read, "Red				
	1	tinues with dark filled blister				
	intact." The pressur	re ulcers were not staged.				
		ssment Monitoring form dated				
		two pressure ulcers on the				
		cription which read, "Red				
		tinues with dark filled blister				
		re ulcers were documented as				
	"Unstageable."	ssment Monitoring form dated				
		two pressure ulcers on the				
		cription which read, "Red				
		tinues with dark filled blister				
		re ulcers were documented as				
	"Unstageable."					
		11/20/14, at 9:26 a.m.				
	registered nurse (R	N)-D stated the RNs were				

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING \_\_\_ 00109 11/24/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

NAIVIE OF F	PROVIDER OR SUPPLIER STREET ADI	DRESS, CITT, S	STATE, ZIP GODE	
COMMUN	NITY MEMORIAL HOME	MAIN STRI	EET	
(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) COMPLETE DATE
2 625	responsible for completing the Wound Assessment/Monitoring forms. Upon review of R21's wound forms and descriptions, RN-D stated all the assessments which had noted R21's left heel pressure ulcers to have been at a stage one, had been staged incorrectly, and appeared from the description to be at least a stage two.  During interview on 11/20/14, at 1:41 p.m. consulting dietician (D)-A stated she had not been contacted after the development of R21's pressure ulcers because they were noted to be stage one, and typically stage one ulcers did not warrant nutritional interventions for healing. D-A stated only if the pressure ulcers were a stage two or worse, would immediate nutritional interventions be required to be put into place. D-A was unaware R21's left heel pressure ulcers had been staged incorrectly, and if D-A had known R21 had pressure ulcers worse then a stage one, additional nutritional interventions would have been put into place to promote healing. The facility policy titled Purpose of the Medical Record Policy Statement dated 4/16/13, indicated a medical record would be maintained to provide complete and accurate resident information for continuity of care.  SUGGESTED METHOD FOR CORRECTION: The DON and/or designee could monitor to assure the maintenance of accurate, complete, and organized clinical information about each resident. The DON or designee could also perform audits of resident records and report findings to the quality assurance committee.  TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 625		

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING	B. WING		4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HO	ME 410 WEST OSAKIS, I	MAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 12	2 830			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General		2 830			12/20/14
	receive nursing carcustodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.				
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide proper wheelchair positioning for 4 of 4 residents (R1, R10, R50, and R47) reviewed for wheelchair positioning.			Corrected		
	Findings include:					
	R1's quarterly Minimum data set (MDS) dated 10/23/14, identified the resident had no cognitive impairments, required extensive assistance of two staff with transfers, and total assistance of one staff for locomotion on and off the unit.					
		d 11/21/14, identified R1 used be of reclining wheelchair) for ting.				
	During observation	on 11/17/14, at 6:34 p.m. R1				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		.,
COMMU	NITY MEMORIAL HOI	ИE	MAIN STRE	EET		
	T	OSAKIS, I	MN 56360			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 830	Continued From page 13		2 830			
	was observed sitting in a BRODA wheelchair with her feet dangling above the foot rest, and a wheelchair cushion seat was propped beneath her legs.					
	R1 was again obse down on her wheel support, and wheel her feet. R1 was cop.m. when nursing in bed. R1's feet refoot rest with no su	on 11/18/2014, at 2:35 p.m. rved with her feet dangling chair footrest with no foot chair cushion remained behind ontinuously observed until 3:27 assistant (NA)-A laid R1 down emained dangling above the pport for almost an hour.				
	During interview on 11/18/14, at 3:17 p.m. NA-B and NA-D stated R1 had been in her current wheelchair for about a year. Neither NA was sure of the facility procedure for assigning wheelchairs. NA-D stated R1 preferred wheelchair cushions underneath her legs, because her feet dangled and did not have any support, and stated they dangled. She further stated R1's positioning in the chair was "not very good" if the pillows were not in place.					
	NA-D stated reside based on decisions	view on 11/18/14, at 3:28 p.m. nts received their wheelchairs made at the interdisciplinary he licensed nurses.				
	occupational therape the BRODA chairs had been put in her weight and needing lacked another type would fit R1. OT w if R1's current when resident. OT state	11/20/14, at 2:08 p.m. the bist (OT) stated she disliked for residents. OT stated R1 current chair due to gaining a larger chair, and the facility of reclining wheelchair which as not involved in determining elchair was appropriate for the d she reported concerns of equipment for all residents to				

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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
COMMUNITY MEMORIAL HOME  410 WEST MAIN STREET OSAKIS, MN 56360  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 830  Continued From page 14  management as recently as the previous week, however, the facility's funding for wheelchair equipment was limited.  (X5) PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  2 830  Continued From page 14  management as recently as the previous week, however, the facility's funding for wheelchair equipment was limited.			00109	B. WING		11/2	4/2014
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 830  Continued From page 14  management as recently as the previous week, however, the facility's funding for wheelchair equipment was limited.  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  2 830  2 830			410 WEST	MAIN STRE			
management as recently as the previous week, however, the facility's funding for wheelchair equipment was limited.	PREFIX	(EACH DEFICIENCY M	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
resident had severe cognitive impairment, was a total assist of two staff for all transfers, and required total assistance of one staff member for locomotion in her wheelchair.  R10's face sheet dated 11/21/14, indicated diagnoses including degeneration of the intervertebral discs and osteoporosis.  R10's care plan dated 11/21/14, indicated the resident was wheeled by staff to all destinations, and used a pressure reducing wheelchair cushion.  R10's most recent OT therapy notes dated 5/20/14, did not address any wheelchair positioning needs for R10.  During observation on 11/18/14, at 10:55 a.m. R10 was observed leaning to the side and sliding down in a BRODA wheelchair and had a wheelchair cushion tucked beneath her legs.  During observation on 11/20/14, at 10:39 a.m. R10 was observed in her wheelchair and was in a slouched position, with the wheelchair seat at the mid-thigh level.  During interview on 11/18/14, at 3:28 p.m. NA-D stated residents received their wheelchairs based on decisions made at the interdisciplinary team meetings by the licensed nurses.  During interview on 11/20/14, at 2:08 p.m. OT stated she had not seen R10 for wheelchair	2 830	management as rece however, the facility's equipment was limited R10's quarterly MDS resident had severe of total assist of two staff required total assistar locomotion in her who R10's face sheet dated diagnoses including of intervertebral discs ar R10's care plan dated resident was wheeled and used a pressure cushion.  R10's most recent OT 5/20/14, did not addrepositioning needs for During observation or R10 was observed leadown in a BRODA who wheelchair cushion tuburing observation or R10 was observed in slouched position, with mid-thigh level.  During interview on 1 stated residents received on decisions made at meetings by the license During interview on 1 stated review on 1 stated review on 1 stated residents received on decisions made at meetings by the license During interview on 1 stated review on 1 stated rev	ently as the previous week, a funding for wheelchair ed.  dated 9/25/14, indicated the cognitive impairment, was a aff for all transfers, and ince of one staff member for eelchair.  ed 11/21/14, indicated degeneration of the and osteoporosis.  d 11/21/14, indicated the d by staff to all destinations, reducing wheelchair  T therapy notes dated ess any wheelchair  R10.  In 11/18/14, at 10:55 a.m. eaning to the side and sliding heelchair and had a ucked beneath her legs.  In 11/20/14, at 10:39 a.m. her wheelchair and was in a ath the wheelchair seat at the side their wheelchairs based at the interdisciplinary team ased nurses.	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
СОММИ	NITY MEMORIAL HO	MIE	T MAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 15	2 830			
	positioning.					
	R50's quarterly MDS dated 9/11/14, indicated the resident had severe cognitive impairment and was an extensive assist of one with locomotion.					
	R50's care plan dated 11/21/14, indicated R50 used a BRODA chair and was wheeled by staff to all destination.					
	During observation on 11/17/14, at 6:58 p.m., R50 was observed in a reclined BRODA chair with no foot support, his feet were dangling and did not touch the floor.					
	During continuous observation on 11/18/2014, from approximately 2:00 p.m. through 3:32 p.m., R50 was observed sitting in his reclined wheelchair at the entrance to the east hallway. R50 was moving his feet in his wheelchair as if trying to propel himself, however, R50 was unable to move as his feet did not touch the floor.					
	was observed seated dining room. The Eupright position, an	on 11/19/14, at 7:51 a.m. R50 ed in the BRODA chair in the BRODA chair was in the d R50's feet were dangling I did not touch the floor.				
	occupational therap put in the BRODA of kyphosis (a condition curvature of the spi wheelchair position	11/20/14, at 2:08 p.m. the bist (OT) stated R50 had been chair due to a diagnoses of on that causes excessive ne). OT stated R50's ing was, "Not very good," and a feet should touch the floor so nself.				
		S dated 8/7/14, indicated the cognitive impairment and				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
сомми	NITY MEMORIAL HO	ME	ΓMAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	destinations with a  R47's care plan datused a wheelchair in  R47's OT therapy in  R47 had weakness in space wheelchair  R7's nursing progrefollowing:  -11/6/14, at 10:42 aleaning forward in victorial in  -11/13/14, at 4:04 planter wheelchair  -11/15/14, at 5:37 aleaning observation  R47 was observed wheelchair seat application in wheelch  During observation  R47 was observed wheelchair seat application in wheelchair seat application in wheelchair seat application in wheelchair seat application in wheelchair and falle wheelchair and falle wheelchair position  During interview on stated R47's position different wheelchair cover a different whool have another seat application.	staff assistance to and from wheelchair.  ted 11/21/14, indicated R47 for all mobility.  notes dated 11/12/14, indicated and poor positioning in her tilt r.  ess notes identified the  n.m Recent falls, trend of	2 830			

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
COMMUI	NITY MEMORIAL HON	ME 410 WEST OSAKIS, N	MAIN STRI NN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	stated although at t body alignment, she wheelchair. OT had vendor the previous wheelchair option the R47's needs, howenew chairs was limited R47 with an approparties of Nuring observation R47 was observed down in her wheelcherself down the had During interview on administrator stated equipment needs, hany concerns related wheelchair equipment of Nuring interview on administrator stated equipment needs, hany concerns related wheelchair equipment of Nuring interview on administrator stated equipment needs, hany concerns related wheelchair equipment of Nuring interview of Nuring in	equipment to the facility, and imes R47 might be in good a could benefit from a different brought in a wheelchair week to demonstrate a nat would be customizable for ver, the facility's funding for ted and was unable to provide riate fitting wheelchair.  on 11/21/2014, at 9:30 a.m. in a slouched position, sliding hair while trying to propel allway.  11/21/14, at 1:53 p.m. the different the facility discussed nowever, he was not aware of a do lack of appropriate fitting ent for residents.  Wheelchair positioning was rovided.  CHOD OF CORRECTION: sing or designee could the procedures regarding itoring approprate positioning. sing or her designee could a policies and procedures, and ag system to ensure residents.	2 830			
2 920		5 Subp. 6 B Rehab - ADLs of daily living. Based on the	2 920			12/20/14

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HO	ИF	「MAIN STRI VIN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	comprehensive res home must ensure B. a resident who activities of daily liv	ident assessment, a nursing that: is unable to carry out ing receives the necessary good nutrition, grooming,	2 920			
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 4 of 13 residents (R25, R40, R46 and R58) who required staff assistance to eat received timely assistance with dining. Findings include: R25's quarterly Minimum Data Set (MDS) dated 10/16/14, identified R25 was severely cognitively impaired and required extensive assistance with eating.			Corrected		
	11/17/14, at 6:03 p. front of her, and a v present at the table plate of food was ju p.m., 18 minutes la sat down and assis At 6:29 p.m. NA-A writing on a piece of from R25. At 6:52 sat down and assis and at 6:59 p.m. R2 room. R25's meal approximately 25% R40's annual MDS was severely cogni	dated 10/9/14, identified R40 tively impaired and totally				
	dependent on staff					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00109	B. WING		11/2	24/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
COMMI	JNITY MEMORIAL HON	410 WES	T MAIN STRE	ET		
COMM	JNITT WEWORIAL HOR	OSAKIS,	MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 920	During observation 11/17/14, at 6:04 p. R40. At 6:14 p.m., to feed R40 for four again to feed anoth later, at 6:25 p.m., until 6:48 p.m., and dining room. R40's R40 ate approxima  R46's annual MDS was severely cognit extensive assistance. During observation 11/17/14, at 6:03 p. at the dining room t liquids in front of hetable to assist R40 when TMA-A sat do R46 was taken out p.m. R46's meal was taken out p.m. R46's meal was severely cognit extensive assistance. R58's quarterly MD R58 was severely cognit extensive for and the resident atem meal.  R58's quarterly MD R58 was severely cognit extensive for and the resident atem meal. R58's quarterly MD R58 was severely cognitive extensive for any observation 11/17/14, at 6:03 p. at the dining room to variety of liquids on 6:09 p.m. (6 minute R58 and gave her significant extensive for a finite state, at 6:1 stool she was sitting table and began to	of the evening meal on m., NA-A got up from feeding NA-A returned and continued minutes, and then left R40 er resident. Seven minutes FMA-A sat down and fed R40 then wheeled her out of the meal lasted 44 minutes, and tely 90% of the meal  dated 8/21/14, identified R46 tively impaired and required				

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PRINTED: 12/23/2014

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING \_\_\_ 00109 11/24/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **410 WEST MAIN STREET** COMMUNITY MEMORIAL HOME

COMMU	COMMUNITY MEMORIAL HOME OSAKIS,			
(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) COMPLETE DATE
2 920	Continued From page 20	2 920		
	R58 until 6:49 p.m., at which time R58 was taken out of the dining room R58's meal lasted about 46 minutes, and ate approximately 25% of the meal .			
	During interview on 11/20/14, at 2:10 p.m. TMA-A stated there were usually four staff in the dining room during the evening meal to assist approximately 12 residents. TMA-A stated staff usually feed the residents who could eat the fastest first, and then move on to the other residents who need assistance.			
	During interview on 11/20/14, at 4:24 p.m. registered nurse (RN)-A stated there was usually three to five staff assisting approximately 11 residents who need assistance with eating in the dining room during the evening meal. RN-A stated the resident who arrived in the dining room first, got fed first. RN-A stated staff should focus on feeding one to two residents at a time, and residents who are unable to be assisted timely should have their food held in the warmer instead of sitting out on the table and getting cold.			
	During interview on 11/20/14, at 5:22 p.m. NA-D stated residents should be fed as they entered the dining room to prevent their food from getting cold.			
	The facility policy titled Feeding a resident dated 6/7/10, indicated residents were to be assisted with eating in a manner that maintained or enhanced each resident's dignity and respect. The policy did not address providing timely assistance to residents.			
	SUGGESTED METHOD OF CORRECTION:			
	The director of nursing (DON) and/or designee could review or revise policies, provide education			

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.	·		
		00109	B. WING		11/24/2014	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COMMU	NITY MEMORIAL HO	ME	「MAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 21	2 920			
	during dining. The					
	Fourteen (14) days					
2 965	965 MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home		2 965			12/20/14
	must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served.					
	by: Based on observati review, the facility f with significant weig	ent is not met as evidenced ion, interview, and document ailed to ensure 2 of 3 residents ght loss (R21 and R50) were ssessed to ensure nutritional		Corrected		
	Findings include:					
	developed multiple	ificant weight loss and pressure ulcers, however no 21's nutritional status was				
		to the facility on 9/15/14, and Minimum Data Set (MDS)				

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PRINTED: 12/23/2014 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00109 11/24/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **410 WEST MAIN STREET COMMUNITY MEMORIAL HOME OSAKIS, MN 56360** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 9 6 5 Continued From page 22 2 965 dated 9/20/14, which identified R21 was severely cognitively impaired and was totally dependent on staff for eating. R21's care plan dated 11/18/14, identified R21 required assistance with eating, received a modified texture diet and was lactose intolerant. The goal was to maintain weight and staff were directed to monitor food and fluid intake. A nutritional risk assessment completed 9/23/14, identified R21's weight was 159 pounds, received a regular, pureed texture diet, and was unable to make meal/food preferences known. The assessment also noted R21 was totally fed by staff and did not make any attempt to feed himself. A Comprehensive Skin Assessment dated 9/15/14, indicated R21 was chair fast, was cognitively impaired, was unable to voice needs and was dependent on staff for cares and to anticipate needs. The assessment noted there were no pressure ulcers on admission. A Wound Assessment/Monitoring form dated 10/20/14, identified the presence of two left heel pressure ulcers. The wounds were noted to be

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stage one. Specific interventions listed included adjusting foot pedals, discontinue the use of TED stockings, and a pillow under feet in the chair and in bed. The form did not include any dietary

The left heel wounds were assessed on 10/27/14. 11/3/14, and 11/6/14. Each assessment noted the left heel wounds to be stage one, and the

On 11/14/14 the Wound Assessment/Monitoring

assessment or interventions.

interventions remained unchanged.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00109	B. WING		11/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
0014141	NITY MEMORIAL LICE	410 WES	MAIN STRI	EET		
COMMO	NITY MEMORIAL HOI	OSAKIS, I	MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	form noted the left to an untraceable le continuing to float he wheelchair remained facility identified the worse indicating the interventions were dietary to ensure any encourage healing.  R21's documented 9/17/14 159 pound 10/1/14 156.5 10/8/14 156.5 10/8/14 156.5 10/22/14 149.5 a 6% decrease from 10/29/14 148.5 flagged as a 5.1% or 11/12/14 148 promise in terror in a resident had and she would compassessments to enappropriate nutrition promote healing. Didentified at nutrition reviewed by the conthe computer system.	heel wounds to have declined evel. The interventions of heels while in bed and in ed unchanged. Although the expressure ulcers had gotten ey were now unstageable, no changed, including contacting propriate nutrition to weights included the following: ds pounds ounds pounds which was flagged as m 159 pounds pounds which was also decrease from 156.5 pounds ounds oun	2 965			
	weight loss on 10/2 she had been notifi pressure ulcers on although R21 had a	ed R21 had first triggered for 2/14, with a loss of 6% and ed of the developed stage one 10/20/14. DM confirmed a weight loss of >5%, and had pressure ulcers, no				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET AD			STATE, ZIP CODE		
COMMU	NITY MEMORIAL HO	ME 410 WEST OSAKIS, I	MAIN STRE	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 965	reassessment of Ribeen completed, no put into place nutrit weight loss or aid ir "It got missed."  During interview on registered nurse (Rhad been complete after the weight loss pressure ulcers. Rjust been started or you on Monday, I re [R21] on a supplemany documentation indicated the dietici regarding R21's we pressure ulcers. Rh floor were the ones the Wound Assessive review of the wound RN-D stated all the noted R21's left her been at a stage one and they should har In addition, RN-D synotified when R21's noted to go from standard in the property of the work o	21's nutritional status had or had any interventions been ionally to prevent further in wound healing. DM stated,  11/20/14, at 9:26 a.m.  N)-D stated no reassessment d of R21's nutritional status is or the development of the N-D stated a supplement had in 11/17/14, "After I talked to ealized that I had not started itent." RN-D was unable to find in R21's record which an had been consulted ight loss or worsening N-D stated the RN's on the responsible for completing ment/Monitoring forms. Upon d forms and descriptions, assessments which had ell pressure ulcers to have et, had been staged incorrectly, we been staged at a stage two tated she had not been age one to unstageable.  11/20/14, at 10:46 a.m.  (D)-A stated she visited the imonthly if the census was ell would expect to be notified if the or greater weight loss, or dessure ulcer.	2 965			
	p.m. D-A stated she the development of	e had not been contacted after R21's pressure ulcers noted to be stage one, and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

O0109

B. WING

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

410 WEST MAIN STREET

OSAKIS, MN 56360

COMMUI	COMMUNITY MEMORIAL HOME  410 WEST MAIN STREET  OSAKIS, MN 56360						
(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) COMPLETE DATE			
2 965	Continued From page 25	2 965					
	typically stage one pressure ulcers did not warrant nutritional interventions for healing. D-A stated if a resident had a pressure ulcer of a stage two or worse, immediate nutritional interventions would be put into place. D-A was unaware R21's left heel pressure ulcers had beer staged incorrectly, and stated R21 should have been on a nutritional supplement for weight loss and pressure ulcer healing.						
	The undated facility policy titled Referrals to Dietician indicated as problems arise, staff would inform the DM and the DM would inform consultant dietician as needed. Further, the policy identified the DM would provide the dietician with a list of residents who had a stage one, two, three or four pressure ulcer, tube feedings or significant weight loss.						
	R50's quarterly MDS dated 9/11/14, indicated R50 was on a therapeutic diet, was not on a planned weight loss program, and required supervision of one staff member for eating.						
	R50's most recent nutritional progress note assessment, completed by D-A on 9/23/14, indicated R50 weighed 144.5 lbs and was on a diabetic Boost supplement (a type of high-calorie supplement) twice daily.						
	R50's nursing Progress Note dated 10/1/14, indicated R50's Boost supplement was discontinued because the resident was eating all of his meals.						
	R50's food and fluid intakes for 10/1/14, to 11/15/14, indicated variable intakes between 0-100% at meals.						
	R50's weights in the electronic medical record						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COMMUNITY MEMORIAL HOME 410 WEST OSAKIS, M		T MAIN STRI MN 56360	≣ET .			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	indicated the follow 11/18/2014 - 136.0 11/11/2014 - 136.0 11/4/2014 - 135.0 lt 10/28/2014 - 134.5 10/21/2014 - 137.5	lbs lbs os lbs				
	10/14/2014 - 140.0 10/7/2014 - 142.5    9/30/2014 - 145.0	lbs os				
	R50 was eating his meal in the dining room. He ate all of his oatmeal, several bites of an omelette, and drank all of his coffee.					
	stated she came to nurses maintained on supplements. Description of they were eating concerns. D-A states flag residents with and the D-M monitorshe was not made loss in the past 45 possible restarting	11/20/2014, at 10:58 a.m. D-A the facility monthly and the a list of which residents were 0-A stated the nurses would nal supplements for residents well because of budget ed nurses were responsible to weight loss for D-A to review, ored the weights. D-A stated aware of R50's 9 pound weight days, and she would look at R50's Boost supplement.				
	stated R50's nutritic discontinued a little the resident had be however, RN-B star	11/20/14, at 4:29 p.m. RN-B conal supplement had been over a month ago because then eating all of his meals, ted R50's nutritional being restarted today related to ss.				
	stated R50 was tak	11/21/14, at 9:08 a.m. the DM en off the supplement ined weight. She stated R50's				

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PRINTED: 12/23/2014 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ B. WING 00109 11/24/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **410 WEST MAIN STREET COMMUNITY MEMORIAL HOME OSAKIS, MN 56360** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 9 6 5 Continued From page 27 2 9 6 5 weights were monitored by the bath aide, and the bath aide was responsible to let nursing know if a resident has weight loss, and then nursing should let DM know of the nutritional concern. The DM stated she monitored resident weights with the quarterly and annual MDS. The undated facility policy titled Nutrition Risk indicated residents would be assessed periodically for the presence of nutrition risk. Potential risk indicators included weight loss, e.g., (5# in one month) or cumulative weight loss, e.g., (10# in three months). The policy further stated the risk determination will usually be made at the time when significant weight changes occur, and that the nursing documentation should include insights into the nutrition problems on a regular basis. Review of the facility policy titled Significant Weight Loss dated 10/12/10, indicated residents would be considered to have significant weight loss if they had greater than 5% weight loss in one month or greater than 7.5% weight loss in three months. The procedure within the policy gave direction to: Assess whether or not the weight loss was desirable Assess laboratory values Assess feeding ability, chewing/swallowing ability, tolerance/acceptance of diet etc.

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potential causes.

· Assess the risk of malnutrition. Identify

SUGGESTED METHOD OF CORRECTION: The registered dietitian with the director of nursing could ensure a system for flagging residents who have experienced significant weight changes or who are nutritionally at risk. A

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00109	B. WING		11/2	24/2014
COMMUNITY MEMORIAL HOME 410 WEST		DRESS, CITY, S T MAIN STRI MN 56360	STATE, ZIP CODE EET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 965	plan could be devis nutritional needs ar Audits could period	ge 28 ed to ensure each residents' e met to the extent possible. ically be completed. R CORRECTION: Fourteen	2 965			
21015	Requirements- Sai Subp. 7. Sanitary procedures and cor the operation of the times.  This MN Requirement	O Subp. 7 Dietary Staff nitary conditions. Sanitary nditions must be maintained in dietary department at all	21015			12/20/14
	review the facility far machine in a sanital possibility of food be potential to affect a residing in the facilitie machine.  Findings include:  During initial kitcher	on, interview, and document illed to maintain the ice ry manner to minimize the orne illness. This had the il 36 residents currently ty who recieved ice from the		Corrected		
	the kitchen, in the factor ice machine a gree covering the compound where the ice was recovered the water part damper, distribution addition, there were substance which ra	e was observed just outside acility dining room. Inside the n substance was observed onents in the top right corner made. The green substance outpour, water trough, ice n tube, and evaporator. In a two trickles of the green n from the components down disappeared behind the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00109	B. WING		11/2	24/2014
COMMUNITY MEMORIAL HOME 410 WES		DRESS, CITY, S MAIN STRI MN 56360	STATE, ZIP CODE EET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21015	already made ice sidietary manager (D substance, and state been moved to the living building on 11 cleaning schedule so During interview on Maintenance (M)-A moved in the dining 11/14/14. M-A state machine to the facil room, he rinsed the but did not take it a scrub off the green green substance wasn't 100% certain During a follow up of 10:37 a.m. the gree in the ice machine. with a clear plastic substance turned the and was able to be M-A removed the machine with a clear plastic substance turned the and was able to be M-A removed the machine be cleaned months and must be sanitizing. Review of the unda Production, Storage indicated manufact should be used. The surfaces should be attention to door transport of the surfaces should be attention to door transport of the surfaces should be attention to door transport of the surfaces should be attention to door transport of the surfaces should be attention to door transport of the surfaces should be attention to door transport of the surfaces should be attention to door transport of the surfaces should be attention to door transport of the surfaces should be attention to door transport of the surfaces should be attention to door transport of the surfaces should be attention to door transport of the surfaces should be attention to door transport of the surfaces should be attention to door transport of the surfaces should be attention to door transport of the surfaces should be attention to door transport of the surfaces and surfaces should be attention to door transport of the surfaces and surfaces are surfaces are surfaces and surfaces are surfaces and surfaces are surfaces and surfaces are surfaces are surfac	tting in the ice machine. The M) verified the green ted the ice machine had just dining room from the assisted /14/14, so there was not a set up yet.  11/17/14, at 1:29 p.m. stated the ice machine was room at the facility on d when he brought the ice lity and installed it in the dining machine quickly with bleach, part, made no attempts to substance. M-A thought the las a copper build up, but	21015			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					OATE SURVEY OMPLETED	
		00109	B. WING	<del></del>	11/2	4/2014
	PROVIDER OR SUPPLIER	410 WES	DRESS, CITY, S T MAIN STRI MN 56360	STATE, ZIP CODE EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	to assure that the ic sanitary manner. St necessary. The Cer monitor the cleaning periodic basis.	ge 30 nachine policy and procedure te machine is cleaned in a taff could be trained as rtified Dietary Manager could g of the ice machine on a	21015			
21230	Subp. 2. Duties. T conjunction with the director of nursing s for:	O Subp. 2 B Medical Director; re Policies  the medical director, in a administrator and the services, must be responsible tion of resident care policies;	21230			12/20/14
	by: Based on interview facility medical direction and collaboration with development, imples abuse prohibition perfacility. This deficies	and document review, the ctor failed to provide guidance ith the facility staff related to ementation, and evaluation of olicies and procedures in the ent practice had the potential to its currently residing in the		Corrected		
	to ensure 5 of 8 res and R12) who mad neglect, and/or mis provided follow up a	ne facility administration failed idents (R52, R58, R44, R47 e allegations of staff abuse, treatment were protected and and resolution to prevent from occurring. The facility's				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00109	B. WING		11/2	24/2014
COMMUNITY MEMORIAL HOME 410 WEST		DDRESS, CITY, ST T MAIN STRE MN 56360				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21230	lack of identification residents, resulting residents from staff abuse, as well as the interventions to presented in an immeresidents currently remained at risk of and/or mistreatment. Refer to F225, as the administrator and sell allegations of stamps and the staff abuse, neglectore reported to the admended and were thorough limmediate Jeopard currently residing in Refer to F226, as the abuse prevention proposed in the staff abuse, neglectore reported for 5 of R47 and R12) who abuse prevention proposed in the staff abuse prevention proposed for sellity failed to repose and/or administrator thorough investigation potential mistreatm affect all 36 resider facility.  During interview on	n of staff mistreatment to in lack of protection for a neglect, mistreatment, and ne lack of developing vent further staff abuse, ediate jeopardy for all 36 residing in the facility who potential staff abuse, neglect, at.  The facility failed to report to the tate agency, and investigate, aff abuse, neglect, and/ or of 8 residents (R52, R58, R44, made allegations of staff failure of the facility to ensure ace regarding all allegations of t, and mistreatment were ninistrator and state agency, y investigated, resulted in an ly (IJ) for all 36 residents				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00109	B. WING		11/24/2014	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
СОММИ	NITY MEMORIAL HO	ME	T MAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21230	identified in the facily April 2014, and had nursing (DON) early concerns of lack of incidents of staff midilure to report incidents of staff midilure to report incidents administrator. The involved in develop the previous survey specific education values. The MD stafacility on a quarter assurance meeting meetings unless he he needed to see, a patients he was the facility. MD stated reports, but could nunusual decrease in his review.  The undated facility Description indicated DON with resolution issues, and would predical care provided to ensure the higher at all times. Addition medical director was and regulations affes services and ensure services and ensure services and ensure services and ensure services related facility could ensure facility could ensure services and ensure services and ensure services related facility could ensure facility faci	previous abuse situations altity during the last survey in a spoken with the director of iter this week about the current investigation of alleged istreatment to residents and dents to the state agency and MD indicated he was not very ing the plan of correction for and had not done any with the facility staff related to ated he was typically in the lay basis for the quality and did not come in between a had a resident in the facility and currently MD had no a primary doctor for in the he reviewed resident incident not recall if he had seen an an incidents being forwarded for a Medical Director Job and the MD should assist the most and it is the keep updated on rules are the head of the medical standards are met anally, the policy indicated the last the keep updated on rules are the head of the medical staff are educated.  THOD OF CORRECTION: The provide oversight to the garding facility policies and to abuse prohibition. The are the medical director reviews are the medical director reviews are and the medical director reviews are a	21230			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00109	B. WING	<del></del>	11/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
сомми	NITY MEMORIAL HO	Λ <b>Ε</b>	「MAIN STRI VIN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21230	ongoing compliance investigation and in requirements. The complete training reto reporting and inv	e with abuse reporting, terim resident protection facility medical director could elated to regulations pertinent estigation of alleged abuse, nd other medical providers.	21230			
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance  Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.  This MN Requirement is not met as evidenced by:  Based on observation, interview, and document review, the facility failed to ensure proper handwashing techniques to prevent cross contamination for 2 of 2 residents (R53, R47) observed during personal cares, and for 1 of 1 resident (R16) observed during a glucometer check.  Findings include:		21385	Corrected		12/20/14
	resident required ex staff for personal hy During observation hospice nursing ass	S dated 9/18/14, identified the stensive assistance of two rgiene and toileting.  on 11/19/14, at 8:12 a.m. the sistant (HNA) and nursing ere providing personal cares to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00109	B. WING		11/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COMMU	NITY MEMORIAL HOI	MI	T MAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21385	R50. HNA emptied into a urinal with gle in the toilet and rins dumping the rinse whung the urinal on the bathroom and remove washing her hands bedside and proced resident side to side gloves and took an R50's skin during phecame visibly soile After wiping R50, Nothrew them in the ghands, NA-E proced mechanical lift sling resident's shoulder the process.  During interview on confirmed she had removing the soiled hands immediately HNA stated she had her gloves after emurine, however, had have.  R47's quarterly Min 8/18/14, identified fill impairment, require activities of daily livincontinent of bower During observation nursing assistant (Notes a single servation and single	I R50's urinary catheter bag oved hands, dumped the urine sed the urinal with water, water into the toilet. HNA then the garbage can in the oved her gloves. Without, the HNA returned to the edded to help NA-E roll the efor peri care. NA-E applied incontinent wipe to cleanse veri-care. NA-E's gloves ed with stool when wiping R50. IA-E removed her gloves and varbage. Without washing her edded to hook R50 up in a g, touching the sling, the s, and the shower chair during a 11/19/14, at 8:25 a.m. NA-E not washed her hands after d gloves and would wash her after she left the room. The d, "thought about" removing aptying R50's catheter bag of d not done this and should slimum Data Set (MDS) dated R47 had severe cognitive ed extensive assistance with all ing (ADL'S), and was				
	turn on her right sic R47's incontinent p	es on, and assisted R47 to de, and NA-F pulled down roduct. NA-F stated the contained urine and stool,				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00109	B. WING		11/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COMMI	NITY MEMORIAL HON	410 WEST	MAIN STR	EET		
OSAKIS,			MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21385	Continued From pa		21385			
		eral disposable wipes to clean , wiping R47 with her gloved				
	left hand and then s	switched to wipe with the				
		Without removing the visibly				
		opened the top drawer on d, picked up a tube of				
		ed the cap of the tube,				
		from the tube into her right				
		cap on the tube, laid the tube				
on the bed, and rubbed the ointment on R47's perineal area. Without removing the gloves, NA-F						
		of ointment from the bed,				
		put the tube of ointment into				
		shed the drawer shut. Without				
		s, NA-F picked up the bed, and				
		ne bedside stand. NA-F				
		glove on her right hand, and				
		to put R47's clean incontinent				
		nen removed the left glove, ssist NA-B to turn and dress				
		on top of a pad used to				
		d although this pad was visibly				
		A-F and NA-B pulled R47's				
		em across the soiled pad.				
		gloves, and NA-F and NA-B o a canvas sling used for the				
	•	g the sling, the lift, R47's				
		pedals, and the privacy				
		ansferred and positioned into				
		F brushed R47's hair and put				
		hout washing her hands, NA-F R47's room touching the door				
		ushed R47 to the dining room				
		ouching both handles on the				
	wheelchair. NA-F p	ositioned R47 at the table,				
		ng protector, placed it on R47,				
		othing protector around R47's				
		back to R47's room, pulled bed, touched the pillow,				

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00109	B. WING	B. WING		4/2014
NAME OF F			<u>l</u>	STATE ZID CODE	11/2	7/2017
	PROVIDER OR SUPPLIER	410 WEST	ress, cri y, s Main Stri	STATE, ZIP CODE		
COMMUN	COMMUNITY MEMORIAL HOME OSAKIS					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21385	picked up a bag that and a bag that cont product, and carried hallway, to a closed then threw the bags disposing of the bag sanitizer to clean he During interview on stated she touched gloves during R47's gloves after providir verified she did not removing her soiled many items in R47's R47's room. NA-F changed gloves after and should have waremoving the gloves During interview on registered nurse (R concerns with peric the NA were providinad re-posted the policy in the soiled ureview. RN-B stated change their gloves cleaning a resident.  The facility policy tit 5/10/14, directed stated the policy in the soiled to review. RN-B stated change their gloves cleaning a resident.  The facility policy tit 5/10/14, directed stated the personal protein the policy in the soiled to review. RN-B stated change their gloves cleaning a resident.  The facility policy tit 5/10/14, directed stated the personal protein the personal protein the policy in the soiled to review. RN-B stated change their gloves cleaning a resident.  The facility policy tit 5/10/14, directed stated the personal protein the pe	on the bedside table, and at contained the soiled linens ained the soiled incontinent of the two bags through the door that she opened, and a into receptacles. After gs, NA-F then used hand er hands.  11/19/14, at 8:43 a.m. NA-F many items with the soiled a cares and did not remove her ng personal cares. NA-F wash her hands after digloves and before touching a room, as well as outside of stated she should have er providing personal cares, ashed her hands after s.  11/20/14, at 1:50 p.m. N)-B stated she had identified are and handwashing when ng care to residents, and she pericare and handwashing utility room for the NA's to dishe would expect staff to a and wash their hands after of bowel movement.  Iled Handwashing Policy dated aff to wash hands after each ent, before serving food or at, after removing gloves and ective equipment, and after lood or other potentially	21385			

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00109	B. WING		11/2	4/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COMMUNITY MEMORIAL HOME			MAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21385	finger with a lancet, the test strip, and w finger with a cotton gloves during this ti read, LPN-B brough cotton ball, and land medication/treatme the left hand, and u her right hand. The glucometer was plated LPN-B proceeded to computer on top of any hand hygiene.  When interviewed of LPN-B stated she who cart, discard the soperform hand hygiene computer. LPN-B whand hygiene after glucose testing.  A facility policy regardlucose testing was suggested Method her designee could regarding infection her designee could procedures and devensure compliance trending was completed.	n alcohol wipe, punctured the placed a sample of blood on riped the blood from R16's ball. LPN-B was not wearing me. After the results were not the glucometer, test strip, bet back to the not cart, carrying the supplies in nlocked her cart with keys in a tiems were disposed of, the block back in the cart, and o enter data onto her the cart without performing on 11/20/14, at 3:30 p.m. would typically return to her illed items appropriately, and the prior to touching the verified she did not perform performing R16's blood arding hand hygiene and blood are requested but not provided.  of Correction: The DON or review policy and procedures control program. The DON or educate staff on policy and velop a monitoring system, to with surveillance analysis and	21385			
21525	MN Rule 4658.1309 Consultation	5 A.B.C Pharmacist Service	21525			12/20/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HON	<b>NF</b>	「MAIN STRI VIN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21525	A nursing home muservices of a pharm Board of Pharmacy A. provides comprovision of pharmathome; B. establishes and disposition of a detail to enable and C. determines accurately maintain controlled drugs is a trivial of the control	ust employ or obtain the racist currently licensed by the who: asultation on all aspects of the acy services in the nursing a system of records of receipt II controlled drugs in sufficient accurate reconciliation; and that drug records are ed and that an account of all	21525	Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00109	B. WING		11/2	4/2014
	COMMUNITY MEMORIAL HOME 410 WES		DRESS, CITY, S MAIN STRE MN 56360	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21525	indicated a Fentany 1/25/14, and the ne until 1/30/14, five of Medication Adminis indicated R25 recei 1/25/14, 1/28/14, and During interview on registered nurse (Rwhy R25's narcotic match indicating whreceived the Fentany had not been off.  R37's admission M the resident had mowedication, and had resident had mowedication, and had resident for pain.  Review of R37's lnoindicated Fentanyl for pain.  Review of R37's lnoindicated a Fentanyl for pain.  Review of R37's lnoindicated a Fentanyl for pain.  Review of R37's lnoindicated a Fentanyl patch on the second patch of the second patch of the second patch of the second patch on the second patch on the second patch on the second patch of R37's Maindicated the resident patch	In patch was administered on ext patch was not administered lays later. However, R25's stration Record (MAR), wed a Fentanyl patch on and 1/30/14.  11/20/14, at 10:15 a.m.  1N)-A stated she was unsure record and MAR did not men the resident actually hyl patch. RN-A stated there error report for R25, and patch counts for the facility  DS dated 9/15/14, identified and PRN (as needed) pain did moderate, frequent pain.  cian orders dated 11/19/14, 25 mcg patch every 72 hours  dividual Narcotic Record of patch was administered and patch was not administered and patch was not administered and lo/9/14, and the next patch ed until 10/13/14, four days patches were also not signed hen destroyed per facility 26/14, 10/2/14. On 10/13/14, nurse's signature, and written	21525			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HOI	MI	T MAIN STRE MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21525	until 9/20/14, six da October 2014, indic patch on 10/8/14, 1 10/13/14.  The facility provider for R37 which identil 10/12/14- "Fentany 10/12/14. No patch were not reordered applied" 10/19/14- "During A Fentanyl patch from resident's left shoul During interview on stated R37 was to every 72 hours for determine why the didn't match, and straining regarding of administration and patches. RN-A stattraining several mo and administration were instructed two off the destruction of stated the facility dipatch destruction pa policy on destroys witness.  During interview on consulting pharmace goes to the facility, Fentanyl patch course.	ays later. R37's MAR for cated R37 received a Fentanyl 0/9/14, 10/12/14, and again on d two Medication Error forms tified the following:  I patch due to be changed on a available to apply Patches when last patch was when last patch was a MM (morning) cares resident's an 10/9/14, was still on lder"  I 11/20/14, at 10:15 a.m. RN-A have a Fentanyl patch applied pain. RN-A was unable to MAR and Narcotic record tated the nurses needed more documentation of destruction of the Fentanyl ted the facility nurses had with ago regarding destruction of Fentanyl patches, and they on nurses must witness and sign of Fentanyl patches. RN-A and not have a specific Fentanyl policy, however, the facility had an all medications with a sign all medications with a cost (CP)- G stated when she she reviews the current along with the Narcotic e Fentanyl patch count is	21525			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00109	B. WING		11/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HO	VIE	TMAIN STRE VIN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21525	Continued From pa	ge 41	21525			
	CP-G stated two nu when a Fentanyl pa resident and destro more education for	actually received the patch. urses should be signing off atch is removed from a yed, and she plans on doing the facility regarding destruction of Fentanyl				
	The facility policy titled Destroying Medications dated 11/5/09, instructed staff all schedule 2-5 narcotic medications are to be witnessed by another nurse, and all other medications will be destroyed by two licensed staff by disposing them in the sewer system.					
	Suggested Method of Correction: The director of nursing (DON) and the Consulting Pharmacist could establish a system to monitor fentanyl patches and ensure there is a policy to instruct nurses on destruction and documentation. The DON could randomly audit the system and report audits to the quality assurance committee.					
	Time Period For Co	orrection: Fourteen- (14) days.				
21530	MN Rule 4658.1310	O A.B.C Drug Regimen Review	21530			12/20/14
	reviewed at least m currently licensed b This review must be Appendix N of the S Surveyor Procedure Requirements in Lo the Department of I Health Care Finance This standard is income.	en of each resident must be conthly by a pharmacist by the Board of Pharmacy. The done in accordance with state Operations Manual, the session of Pharmaceutical Service ong-Term Care, published by Health and Human Services, sing Administration, April 1992. Corporated by reference. It is the Minitex interlibrary loan				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00109	B. WING		11/24/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HON	AF.	Г MAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	system. It is not su B. The pharma irregularities to the a and the attending p must be acted upor physician visit, or so pharmacist. For pu upon" means the ac report and the signi of nursing services C. If the attendi with the pharmacist not provide adequal pharmacist believes being adversely afferefer the matter to t if the medical direct physician. If the me the attending physic justification for the o physician does not must be referred for assessment and as by part 4658.0070. the medical directo must refer the matter	bject to frequent change. cist must report any director of nursing services hysician, and these reports by the time of the next coner, if indicated by the rposes of this part, "acted exceptance or rejection of the ng or initialing by the director and the attending physician. ing physician does not concur 's recommendation, or does te justification, and the set the resident's quality of life is exted, the pharmacist must the medical director for review for is not the attending excical director determines that cian does not have adequate excitant does not have adequate forder and if the attending change the order, the matter or review to the quality surance committee required If the attending physician is or, the consulting pharmacist er directly to the quality surance committee.	21530			
	by: Based on observati review the consulta identify and forward physician for 1 of 1 unnecessary medic psychoactive drugs	on, interview, and document nt pharmacist (CP) failed to irregularities to the attending residents (R1) reviewed for ation who received multiple (medications that have mood and behavior) who ions for use.		Corrected		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HOI	MIE	T MAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	Continued From pa	age 43	21530			
	Findings include:					
	10/23/14, identified impairment, had a depression severity	mum Data Set (MDS), dated the resident had no cognitive PHQ-9 (a test to determine v) score of 2 (minimal xhibited no behaviors.				
	R1 had a history of	use dated 5/16/14, indicated psychiatric illness and was I anxiety, and Cymbalta [an				
	R1's care plan dated 11/21/14, indicated a risk factor for behaviors related to diagnosis of dementia, schizophrenia, bipolar disorder, and anxiety. The care plan identified goals of the resident expressing a feeling of comfort and safety. The care plan identified non-pharmacological interventions for behavior of distraction with activities, exercise, 1:1 visits, encourage rosary, and deep breathing.					
	R1's physician orde current medication	ers, dated 11/21/14, identified orders including:				
	(mg) every day at be dementia/schizophic Buspar (an anxiolytanxiety Clonazepam (an ardaily for anxiety/deicymbalta (an antidefor anxiety/depressing Gabapentin (an antiby mouth twice daily demential)	renia tic) 20 mg twice daily for exiolytic) 0.5 mg three times mentia epressant) 60 mg every day ion/peripheral neuropathy ticonvulsant/analgesic) 300 mg y for dementia/schizophrenia evening, and an additional				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
СОММИ	NITY MEMORIAL HON	ΛF	T MAIN STRE MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	Klonopin (an anxiolineeded for anxiety Zoloft (an antidepreday for anxiety/depreday a dose reduction for anxiolytic). No other relation to R1's multimedications.  Review of R1's behototober- November of feeling anxious, a both were redirected distraction.  During observation was observed in behout was alert and at adverse behaviors, feelings of emotions.  During observation was in the dayroom a flat facial express no adverse behavior.  During interview on and NA-D stated Ribehaviors, only occurrence in the dayroom of the dayroom and NA-D stated Ribehaviors, only occurrence interview on registered nurse (Ribert in the dayroom of the dayroom and NA-D stated Ribehaviors, only occurrence in the dayroom of the dayroom and NA-D stated Ribehaviors, only occurrence in the dayroom of the dayroom and NA-D stated Ribehaviors, only occurrence in the dayroom of the	eytic) 0.5 mg by mouth daily as essant) 75 mg by mouth every ression  sultant reviews for the enths indicated irregularities 14, with relation to considering reference (an er irregularities were listed in tiple psychoactive  avior monitoring sheets for resultant 2014, indicated two episodes and one episode of irritability, ble with 1:1 visits or  on 11/17/14, at 2:20 p.m. R1 d. R1 had a flat facial affect tentive, and displayed no She did not express any all distress.  on 11/18/14, at 2:35 p.m. R1 watching television. She had ion, was alert, and displayed		DEFICIENCY)		
		11/20/2014, at 4:11p.m., the cist (CP)-A stated there were				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7t. Boilebiiro.			
		00109	B. WING		11/2	4/2014
NAME OF P	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COMMUN	NITY MEMORIAL HO	VIE	Г MAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21530	indications for use of drugs. CP-A stated needed to be more condition was being multiple diagnoses further stated Gaba would "never fly," in appropriate diagnose another pharmacist more often, and he return a call.  During interview on RN-B stated R1 was behaviors and did stopic and will not ledisrupt her daily round but to be disrupt her daily round but to be a condition of the psychoactive drug the psychoactive drug the psychoactive drug the medication will be gatarget behaviors. To duplicative drug the monitored and discussion of the psychoactive drug the monitored and discussions. A SUGGESTED MI	oncerns" with the diagnosis or for R1's multiple psychoactive of the medication indications defined as to exactly what greated as there were listed for the medications, and apentin for schizophrenia adicating it was not an idea. CP-A stated there was at that came to the building would have that pharmacist at it go. Her behaviors did not utine.  11/20/2014, at 4:16 p.m. is doing well right now with her show some perseveration on a at it go. Her behaviors did not utine.  11/21/14, at 10:25 a.m. CP-B, and the consultant facility, stated she monitored ectiveness through "trial and the multiple diagnoses and in class therapy for some of the consultant facility, indicated a resident will therapeutic medications unless is needed to treat a specific psychotherapeutic given to treat clearly defined the policy further stated erapy would be closely				

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  410 WEST MAIN STREET  OSAKIS, MN 56360   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO	
COMMUNITY MEMORIAL HOME  410 WEST MAIN STREET OSAKIS, MN 56360  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO	
COMMUNITY MEMORIAL HOME OSAKIS, MN 56360  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO	NAME OF PROVIDER OF
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO	COMMUNITY MEMO
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX (EACH
21530 Continued From page 46 to ensure that residents medication regimens are thoroughly reviewed for unnecessary medications by a consultant pharmacists and irregularities reported to the DON and attending physician; educate all relevant staff. Then develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee.  TIME PERIOD FOR CORRECTION: Fourteen (14) days.  21540 MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring  Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director to retorie with the medical director to retorie with the medical director for review if the medical director determines that the attending physician does not have adequate justification nor the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician tis the medical director,	to ensure thoroughl by a cons reported a educate a monitorin compliance Assurance.  TIME PEI (14) days  21540 MN Rule Usage; M Subp. 2. monitor e unnecess home's periodent's physician home's readequate believes to adversely matter to medical of the medic physician the order change the review to (QAA) co

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HON	<b>1</b>	MAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	This MN Requirements: Based on observation review, the facility facility facility who received in (medications that he and behavior) had caddition, the facility discharged resident medication orders in the medication orde	ent is not met as evidenced on, interview, and document ailed to ensure 1 of 1 residents multiple psychoactive drugs ave significant effect on mood clear indications for use. In failed to ensure 1 of 1 is (R72) with multiple pain had appropriate parameters for mum Data Set (MDS), dated the resident had no cognitive PHQ-9 (a test to determine ) score of 2 (minimal chibited no behaviors.  PSSSMENT (CAA) for use dated 5/16/14, indicated psychiatric illness and was anxiety, and Cymbalta [an is helpful.  d 11/21/14, indicated a risk related to diagnosis of renia, bipolar disorder, and dan identified goals of the is a feeling of comfort and an identified al interventions for behavior of vities, exercise, 1:1 visits, and deep breathing.  rs, dated 11/21/14, identified	21540	Corrected		
	Abilify (an antipsych	notic medication) 10 milligrams				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00109	B. WING		11/2	4/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
COMMUNITY MEMORIAL HOME	E 410 WEST OSAKIS, N	MAIN STRE	ET		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
anxiety Clonazepam (an anxidaily for anxiety/demed Cymbalta (an antidep for anxiety/depression Gabapentin (an antice by mouth twice daily in the morning and expression and anxiety in the morning and expression (an anxiety and anxiety and anxiety and anxiety are dead for anxiety and for anxiety/depression and anxiety and anxiety and anxiety and anxiety and anxiety and anxiety and and and anxiety anxiety and anxiety anxi	dtime for enia c) 20 mg twice daily for stiolytic) 0.5 mg three times entia pressant) 60 mg every day en/peripheral neuropathy convulsant/analgesic) 300 mg for dementia/schizophrenia vening, and an additional entic) 0.5 mg by mouth daily as esant) 75 mg by mouth every ession  vior monitoring sheets for 2014, indicated two episodes end one episode of irritability, le with 1:1 visits or  en 11/17/14, at 2:20 p.m. R1 En had a flat facial affect entive, and displayed no She did not express any distress.  en 11/18/14, at 2:35 p.m. R1 watching television. She had on, was alert, and displayed s.  11/18/14, at 3:26 p.m. NA-A did not have a lot of	21540			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	TION (X3) DATE SURVEY COMPLETED	
		00109	B. WING	<del></del>	11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HON	ΛF	T MAIN STRE MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	any behaviors and various one "legitimate coindications for use of drugs. CP-A stated needed to be more condition was being multiple diagnoses further stated Gaba would "never fly," in appropriate diagnose another pharmacist more often, and he return a call.  During interview on RN-B stated R1 was behaviors and did stopic and will not led disrupt her daily round buring interview on who was the regular pharmacist for the fraction effector," as there were duplicate medication the psychoactive draw the facility policy tit Medications dated on the receive psychot such a medication in condition, and each medication will be garget behaviors. To	was set in her routine.  11/20/2014, at 4:11p.m., the sist (CP)-A stated there were oncerns" with the diagnosis or for R1's multiple psychoactive the medication indications defined as to exactly what greated as there were listed for the medications, and pentin for schizophrenia dicating it was not an ses. CP-A stated there was that came to the building would have that pharmacist  11/20/2014, at 4:16 p.m. s doing well right now with her show some perseveration on a sit go. Her behaviors did not utine.  11/21/14, at 10:25 a.m. CP-B, rly scheduled consultant facility, stated she monitored ectiveness through "trial and e multiple diagnoses and n class therapy for some of ugs.  Ided Psychotherapeutic 3/4/13, indicated a resident will herapeutic medications unless s needed to treat a specific psychotherapeutic given to treat clearly defined he policy further stated trapy would be closely				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00109	B. WING	· · · · · · · · · · · · · · · · · · ·	11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HO	ИF	T MAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 50	21540			
	indicated the reside to recover after fract admission minimum 11/11/14, identified impairment, had be pain medication, ar R72's current care staff to ask the resi analgesia at least 3 R72's Pain Assessing the resident had cowas using PRN paimg, 1-2 tabs every every 6 hours. The assessment was, "for pain Did explaint Did explaint	rogress note dated 11/5/14, ent was admitted to the facility cturing the coccyx. R72's in data set (MDS) dated R72 had no cognitive en receiving PRN (as needed) and had frequent pain.  I plan dated 11/14/14, instructed dent about pain and offer 80 minutes prior to therapy.  I ment dated 11/4/14, indicated instant pain at all times, and in medications of Norco 5-325 4 hours, and Tylenol 1000 mg is summary of R72's painhas PRN Norco and Tylenol in the use of PRN medication re to monitor her for non ues to pain"				
		cian orders dated 11/14/14, prescribed the following PRN				
	mg tablet PRN, 1-2 pain Tylenol Extra Stre mg tablet PRN, Eve R72's physician ord parameters which creceive Tylenol vs N	one- Acetaminophen) 3-325 tablets, every 4 hours for ngth (Acetaminophen) 1000 ery 6 hours for pain. ders did not include directed staff when R72 was to Norco, nor did it instruct staff one or two tablets of Norco.				
	Record (MAR) for N	edication Administration November 2014, indicated 3/14, R72 received 43 doses of				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00109	B. WING		11/2	24/2014
	PROVIDER OR SUPPLIER	AF 410 WES	DRESS, CITY, S F MAIN STRI MN 56360	STATE, ZIP CODE EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21540	Norco. Of the 43 se R72 received 2 tablet of Norco 3 tin received Tylenol 10 of Norco, 2 tablets. Tylenol 1000 mg, as 2 tablets.  During interview on stated when resider medication orders to taking 1-2 tablets, the physician to obtain know what actual deshould receive, or every usually will catch it review, however, Righarmacy review of to the facility. RN-Eshould have instructione Norco or two, as should receive Tyle.  During interview on licensed practical in administered R72 Ner 2 tablets becausignificant pain. LP have PRN pain medication to gresidents range of phave specific orders administered the pathow the resident was now t	eparate administration times, ets of Norco 40 times, and 1 nes. On 11/9/14, R72 00 mg, as well as two doses On 11/10/14, R72 received well as two doses of Norco, 11/20/14, at 9:55 a.m. RN-B nts are admitted with that included ranges, such as the nursing staff should call the specific orders to ensure staff ose of Norco the resident else the consulting pharmacist when doing the pharmacy representation of the pharmacy representation	21540			
	A SUGGESTED ME	ETHOD FOR CORRECTION:				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00109	B. WING		11/2	4/2014
	PROVIDER OR SUPPLIER	410 WEST	DRESS, CITY, S F MAIN STRI MN 56360	STATE, ZIP CODE EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	The director of nurs develop and implento ensure that residunnecessary medicinclude parameters staff. The DON or omonitoring systems compliance and repassurance Commit TIME PERIOD FOR (14) days.	sing (DON) or designee could nent policies and procedures ents do not receive eations, ensure all medications , and educate all relevant designee can develop to ensure ongoing port the findings to the Quality tee.	21540			
21665	A nursing home mufunctional, comfortaenvironment, allowing personal belonging	O Physical Environment ust provide a safe, clean, able, and homelike physical ng the resident to use s to the extent possible. ent is not met as evidenced	21665			12/20/14
	review the facility fa wheelchairs were cobserved with a soi facility failed to ens repair for 1 of 1 res torn armrest. Findings include: On 11/18/14, at 9:3 noted to be full of d	on, interview, and document tiled to ensure resident lean for 1 of 1 residents (R21) led wheelchair. In addition, the ure wheelchairs were in good ident (R47) observed with a 5 a.m. R21's wheelchair was ebris and crumbs on the pad appeared soiled on the right		Corrected		
	On 11/20/14, at 10:	58 a.m. R21 observed sitting				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
СОММИ	NITY MEMORIAL HO	ME	T MAIN STRI MN 56360	<b>≣ET</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21665	in the wheelchair in and dust were note wheelchair.  On 11/20/14, at 1:4 observed R21's wh dirt and debris preshousekeeping, a colon Log (West) was proand December 201 wheelchairs were to the cleaning schedid documentation of botober or November Month Wheelchair requested and recesseptember 2014, a washing of R21's welcleaning/washing the month per policy, a they are brought to and clean. M-A state on R21's wheelchair washing indicated a nursing home shall down as needed, a month according to schedule.  During observation R47's wheelchair welcanish wheelchair welcanish wheelchair washing observation R47's wheelchair welcan wheelchair welcan wheelchair welcan wheelchair whee	the activities area. Debris d below the seat of the  0 p.m. maintenance (M)-A eelchair and verified there was sent. After consulting with ppy of the Wheelchair Washing ovided for October, November, 4, which indicated all resident to be washed twice a month on ule. R21's wheelchair had no seing cleaned / washed during per. A copy of the Twice a Washing Log (West) was seived for May 2014 through and the last documented wheelchair was on 9/18/14. Keeping should be the wheelchairs twice per and if they are heavily soiled, maintenance to take apart ted he has not done cleaning	21665			
	R47's wheelchair w	e. on 11/21/2014, 9:30 a.m. vas again observed with ne left arm rest which was also				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
COMMUI	NITY MEMORIAL HO	ME 410 WEST OSAKIS, I	MAIN STRI MN 56360	±E1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21665	Continued From pa	ge 54	21665			
	noted to be frayed.					
	M-A stated R47's w armrests and he triceresident equipment require repairs, how schedule of inspect	11/24/2014, at 12:26 p.m. Theelchair needed new ed to visually inspect all in disrepair which would vever, there was no maintence ion. MA-A stated staff were to w any equipment that needed				
	administrator stated monitored for equip with issues as soon them. He was unav	11/21/2014, at 2:03 p.m. the d the facility maintenance staff ment in disrepair and dealt as they became aware of ware of any concerns with rmrest that was torn and				
	Repair and Mainter	policy titled Equipment nance indicated maintenance of this equipment checks and seeded.				
	The maintenance of visual inspection of wide to ensure whe	THOD OF CORRECTION: lepartment could include a residents wheelchairs house elchairs were in good repair s could be monitored by the				
	TIME PERIOD FOR (14) days.	R CORRECTION: Fourteen				
21705	MN Rule 4658.1419 Housekeeping, Ope	5 Subp. 6 Plant eration, & Maintenance	21705			12/20/14
		air conditioning, and ing home must operate and				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HOI	MIE	MAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21705	maintain the mechal comfortable and saland humidity levels areas must be main C:  A. For construct nursing home must of 71 degrees Fahr Fahrenheit at all tim B. For existing must maintain a midegrees Fahrenheic C. Variations of the items A and B are abased on document This MN Requirem by:  Based on observative review, the facility froom temperatures reviewed for complite temperatures.  Findings include:  R45's quarterly Min 10/16/14, indicated impairment.  During interview on his room was too considered shirt and worth the thermostat in Funding observation 9:00 a.m. the thermostat in Funding observa	anical systems to provide anical systems in all resident anical resident anical systems to provide anical systems in all resident anical systems to provide and anical resident anical systems to provide anical systems to provide anical systems to provide anical systems in all resident anical syste	21705	Corrected		

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PRINTED: 12/23/2014 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ B. WING 00109 11/24/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **410 WEST MAIN STREET COMMUNITY MEMORIAL HOME OSAKIS, MN 56360** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21705 Continued From page 56 21705 1:40 p.m. with maintenance (M)-A the thermometer read 64 degrees. M-A stated residents can report cold room temperatures to him, or staff can fill out maintenance request forms. M-A stated he does random temperature checks of resident rooms and will check window latches to ensure they are latched, however, he did not keep record of the checks and could not recall any issues with R45's temperature of his room. When interviewed on 11/20/14, at 1:50 p.m. R45 stated he had reported to staff his concerns of the cold temperature in his room. M-A stated he had not received any reports of R45's room temperatures being cold. A undated facility policy titled Policy on Resident Comfort indicated. "At the start of the heating season and monthly during the heating season all thermostats will be checked to ensure resident comfort. After adjustment is made maintenance staff will stop back with-in 24 hours and make

Time Period for Correction: Fourteen (14) days.

adequate.

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getting in."

sure the resident is comfortable and happy with the current temperature. Also making sure that windows are latched to ensure the cold are is not

Suggested Method of Correction: The director of facility operations (DOF) operations or desigee could work with the administrator to update policies and procedures for when to regulate heat for the resident rooms, and ensure a process to monitor resident room temperatures. The DON or designee could perform audits of resident rooms to determine if the temeprature is

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SI COMPLE	
		00109	B. WING		11/24	/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, 9	STATE, ZIP CODE		
		410 WFS	Γ MAIN STRI	,		
СОММИ	NITY MEMORIAL HON	VIE	MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 57	21805			
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805		-	12/20/14
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a				
	by: Based on observatireview, the facility for residents who requesting (R1, R3, R10)	ent is not met as evidenced on, interview, and document ailed to ensure 10 of 13 ired staff assistance with 0, R14, R19, R21, R25, R40, e provided dining assistance in		Corrected		
	9/11/14, identified F	mum Data Set (MDS) dated R1 was severely cognitively red extensive assistance with				
		ated 9/18/14, identified R3 tively impaired and required be with eating.				
	R10 was severely o	S dated 9/25/14, identified cognitively impaired and assistance with eating.				
		dated 8/21/14, identified R14 tively impaired and required be with eating.				
		S dated 8/7/14, identified R19 tively impaired and required				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
COMMUNITY MEMORIAL HOME 410 WEST		DRESS, CITY, S MAIN STRI MN 56360	STATE, ZIP CODE EET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	extensive assistance R21's admission M R21 was severely of totally dependent of R25's quarterly MD R25 was severely of required extensive R40's annual MDS was severely cognic dependent on staff R46's annual MDS was severely cognic dependent on staff R46's annual MDS was severely cognic extensive assistance R58's quarterly MD R58 was severely cognic extensive assistance During observation 11/17/14, from 6:04 assistant (NA)-A was stool which had wharound two tables were assistant (NA)-A was stool which had wharound two tables were and the stool wheel around to an same table or another few minutes, and the resident to assist the rolling on the stool, R19 twice encourage refused to eat. NA-more than a few see	DS dated 9/20/14, identified cognitively impaired and was in staff for eating.  S dated 10/16/14, identified cognitively impaired and was totally for eating.  dated 10/9/14, identified R40 tively impaired and required cognitively impaired and required cognitively impaired and required cognitively impaired and cognitivel	21805			

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STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7.1. 50.25.1.10.1			
		00109 B. WING 11/24			4/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COMMUNITY MEMORIAL HOME 410 WEST OSAKIS, N		T MAIN STRE MN 56360	EET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21805	During the same muntil 6:27 p.m., NAbetween a stool wit chairs placed arour R10, R1 and R3. Dobserved telling R1 now." R1 continued NA-D replied, "I know everyone else for a you." R1 was obsea straw several diffed os o without assist During interview on medication aid (TM four staff in the dinimeal to assist approximately feed the fastest first and the TMA-A stated an horizontal form the beginning the last person who finished eating.  During interview on registered nurse (R three to five staff as residents who required the dining room during the last person who finished eating.	eal observation from 6:03 p.m. D was observed alternating h wheels, and stationary and tables while assisting R21, During the meal NA-D was she was, "Going to help [R21] d to ask for bites of food and bow, we're just going to assist bit. We're not going to forget breat attempting to drink from erent times, but was unable to	21805			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	_	
COMMU	NITY MEMORIAL HO	MF	T MAIN STRE MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ige 60	21805			
	in the warmer inste while waiting.	ead of sitting out getting cold				
	recalled being pres the meal on 11/17/ observing NA-A or	n 11/20/14, at 5:22 p.m. NA-G ent in the dining room during 14. NA-G did not recall NA-D wheeling around the ated it was not a dignified residents.				
	administrator stated using stools with wl feed multiple reside	n 11/21/14, at 1:50 p.m. the d he was aware staff were heels on them and working to ents at the same time. The d it was obviously not ideal.				
	6/7/10, indicated re with eating in a mai	tled Feeding a Resident dated esidents were to be assisted nner that maintained or sident's dignity and respect.				
	The DON or design and/or revise policional all residents' dignity designee could edu	THOD OF CORRECTION: nee could develop, review, es and procedures to ensure y is maintained. The DON or ucate all appropriate staff on ocedures, and develop s to ensure ongoing				
	TIME PERIOD FOR (14) days.	R CORRECTION: Fourteen				
21850	MN St. Statute 144 Residents of HC Fa	.651 Subd. 14 Patients & ac.Bill of Rights	21850			12/20/14
	Residents shall be	om from maltreatment. free from maltreatment as erable Adults Protection Act.				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 11/2	72011
COMMUNITY MEMORIAL HOME		MAIN STRI MN 56360	EET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21850	"Maltreatment" measection 626.5572, sintentional and non-physical pain or injuconduct intended to distress. Every resonn-therapeutic cheexcept in fully doculauthorized in writing resident's physician period of time, and protect the resident others.  This MN Requirement by: Based on interview facility administration residents (R52, R58 made allegations of mistreatment were up and resolution to from occurring. The of staff mistreatment of protection for resonistreatment, and a developing intervent abuse, resulted in a 36 residents curren remained at risk of and/or mistreatment.  The immediate jeon 4:19 p.m. when the comprehensively as implement intervent were involved in allemistreatment, were 11/19/14, at 4:19 p.	ans conduct described in subdivision 15, or the etherapeutic infliction of ary, or any persistent course of a produce mental or emotional ident shall also be free from emical and physical restraints, mented emergencies, or as a for a specified and limited only when necessary to from self-injury or injury to ent is not met as evidenced and document review, the an failed to ensure 5 of 8 as, R44, R47 and R12) who is staff abuse, neglect, and/or protected and provided follow a prevent further staff abuse e facility's lack of identification at to residents, resulting in lack idents from staff neglect, abuse, as well as the lack of tions to prevent further staff an immediate jeopardy for all thy residing in the facility who potential staff abuse, neglect, t.	21850	Corrected		

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-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HON	ΛF	T MAIN STRE MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21850	immediate jeopardy currently residing in removed on 11/24/1 noncompliance remand severity level, when he assisted hit was like to be in pnot provided cares she would, "Shy aw provide cares to severity level, when he assisted hit was like to be in pnot provided cares to he it was like to he impart would in the world of the control of the wheel chairs and stated she though the control of the world of the control of the wheel chairs and stated she reported nurse (RN) case may facility had spoken to the control of the world	(IJ) for all 36 residents the facility. The IJ was	21850			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF	<u> </u>			STATE, ZIP CODE	11/2	
		T MAIN STRE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21850	During interview on stated she was awamale NA transferrir spoken with both Rincident. The DON made to the SA regardinistrator was rallegation, and ther investigation deterrivestigation	a 11/18/14, at 3:35 p.m. DON are of R52's allegation of a ang her roughly, and she had as and the NA about the confirmed no report had been parding the allegation, The not notified immediately of the re was no documented mining what had happened.  a 11/18/14, at 6:29 p.m. social the DON were interviewed mplaint of rough treatment by d R52's family had called her was upset about rough during a transfer. SS-A stated he NA and charge nurse about rer, SS-A stated she had not westigation regarding the views, and she did not report ency or administrator. SS-A ey had spoken with R52 about e resident did not experience didn't believe the allegation of potential abuse, neglect, or determined no report needed state agency. SS-A and DON of documentation regarding any erviews, and the NA who was reatment of R52 had no further ng to ensure further resident				

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME  SITREET ADDRESS, CITY, STATE, ZIP CODE  410 WEST MAIN STREET OSAKIS, MN 56360   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21850  Continued From page 64  reported R52's accusation of rough treatment to the administrator or state agency. RN-B was not aware of any monitoring that was being completed for the NA involved in the allegation, and RN-B did not feel this met the definition of resident mistreatment because R52 did not experience any injury and felt it was more of a misunderstanding between R52 and the NA.  During interview on 11/19/14, at 12:13 p.m., the administrator stated rough transfers of a resident would be handled as a complaint and facility staff would work with the family to resolve the concern, and would only be reported if it rose to the level of mistreatment, for example, an injury resulted from the rough transfer. The administrator was unsure if he was made aware of the allegation of the rough transfer with R52, however, he stated he knew the NA accused of the rough transfer with R52 and he did not believe the NA would		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
COMMUNITY MEMORIAL HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG (EACH DEFICIENCY)  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  21850  Continued From page 64  reported R52's accusation of rough treatment to the administrator or state agency. RN-B was not aware of any monitoring that was being completed for the NA involved in the allegation, and RN-B did not feel this met the definition of resident mistreatment because R52 did not experience any injury and felt it was more of a misunderstanding between R52 and the NA.  During interview on 11/19/14, at 12:13 p.m., the administrator stated rough transfers of a resident would be handled as a complaint and facility staff would work with the family to resolve the concern, and would only be reported if it rose to the level of mistreatment, for example, an injury resulted from the rough transfer. The administrator was unsure if he was made aware of the allegation of the rough transfer with R52, however, he stated he knew the NA accused of the rough transfer			00109	B. WING		11/	24/2014
COMMUNITY MEMORIAL HOME   OSAKIS, MN 56360	NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
(X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21850  Continued From page 64  reported R52's accusation of rough treatment to the administrator or state agency. RN-B was not aware of any monitoring that was being completed for the NA involved in the allegation, and RN-B did not feel this met the definition of resident mistreatment because R52 did not experience any injury and felt it was more of a misunderstanding between R52 and the NA.  During interview on 11/19/14, at 12:13 p.m., the administrator stated rough transfers of a resident would be handled as a complaint and facility staff would work with the family to resolve the concern, and would only be reported if it rose to the level of mistreatment, for example, an injury resulted from the rough transfer. The administrator was unsure if he was made aware of the allegation of the rough transfer with R52, however, he stated he knew the NA accused of the rough transfer.	COMMU	NITY MEMORIAL HON	410 WES	T MAIN STRE	ET		
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21850  Continued From page 64  reported R52's accusation of rough treatment to the administrator or state agency. RN-B was not aware of any monitoring that was being completed for the NA involved in the allegation, and RN-B did not feel this met the definition of resident mistreatment because R52 did not experience any injury and felt it was more of a misunderstanding between R52 and the NA.  During interview on 11/19/14, at 12:13 p.m., the administrator stated rough transfers of a resident would be handled as a complaint and facility staff would work with the family to resolve the concern, and would only be reported if it rose to the level of mistreatment, for example, an injury resulted from the rough transfer. The administrator was unsure if he was made aware of the allegation of the rough transfer with R52, however, he stated he knew the NA accused of the rough transfer	COMMO	NITY WEWORIAL HON	OSAKIS,	MN 56360			
reported R52's accusation of rough treatment to the administrator or state agency. RN-B was not aware of any monitoring that was being completed for the NA involved in the allegation, and RN-B did not feel this met the definition of resident mistreatment because R52 did not experience any injury and felt it was more of a misunderstanding between R52 and the NA.  During interview on 11/19/14, at 12:13 p.m., the administrator stated rough transfers of a resident would be handled as a complaint and facility staff would work with the family to resolve the concern, and would only be reported if it rose to the level of mistreatment, for example, an injury resulted from the rough transfer. The administrator was unsure if he was made aware of the allegation of the rough transfer with R52, however, he stated he knew the NA accused of the rough transfer	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETE
the administrator or state agency. RN-B was not aware of any monitoring that was being completed for the NA involved in the allegation, and RN-B did not feel this met the definition of resident mistreatment because R52 did not experience any injury and felt it was more of a misunderstanding between R52 and the NA.  During interview on 11/19/14, at 12:13 p.m., the administrator stated rough transfers of a resident would be handled as a complaint and facility staff would work with the family to resolve the concern, and would only be reported if it rose to the level of mistreatment, for example, an injury resulted from the rough transfer. The administrator was unsure if he was made aware of the allegation of the rough transfer with R52, however, he stated he knew the NA accused of the rough transfer	21850	Continued From pa	ge 64	21850			
THE DEC. II I'I II I' II AIA II		the administrator or aware of any monitor completed for the N and RN-B did not for resident mistreatme experience any injuring interview on administrator stated would be handled a would work with the and would only be mistreatment, for experience if he was made the rough transfer whe knew the NA according to the complete the com	r state agency. RN-B was not oring that was being IA involved in the allegation, sel this met the definition of ent because R52 did not ry and felt it was more of a petween R52 and the NA.  11/19/14, at 12:13 p.m., the drough transfers of a resident as a complaint and facility staff a family to resolve the concern, reported if it rose to the level of example, an injury resulted sfer. The administrator was ade aware of the allegation of with R52, however, he stated cused of the rough transfer				
		"Above issue was re	em Resolution form indicated, eviewed with [NA-D] on ase manager. [NA-D] stopped				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMPI	
	00109	B. WING		11/2	4/2014
NAME OF PROVIDER OR SUPPLIE		DRESS CITY S	STATE, ZIP CODE	<u>,</u>	.,
	410 WFS	T MAIN STRE			
COMMUNITY MEMORIAL H	OSAKIS,	MN 56360			
PREFIX (EACH DEFICIEI	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21850 Continued From	page 65	21850			
in DON office on incident." There the mistreatment to the state agen During interview stated she remer R58 and NA-D. apologized and reat R58 the was nothing furth stated she had no incident, and it wadministrator or not believe there and R58 had no incident. During interview stated when she incident with R58 wrong, and NA-D again. DON stated re-education or obeing monitored other residents, for the incident, a state agency. Do mistreatment be NA-D knew her apologized. R44's annual ME resident had diag disease, had mo required assistance the province was kept in the E incident involving indicated on 11/3 dining room in his	8/11/14, to apologize for the was no further investigation of to R58, and it was not reported by. In 11/19/14, at 1:30 p.m. RN-B inbered the incident between RN-B stated NA-D had ecognized she was wrong to or she did, so the facility felt there er they needed to do. RN-B of further investigation of the as not reported to the state agency because they did was any abuse that took place ongoing effects from the end NA-D knew how she acted was stated it would not happen ed NA-D did not receive corrective action, NA-D was not no observe her interaction with the was not reported to the end of				

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME  B. WING	14
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  410 WEST MAIN STREET	
410 WEST MAIN STREET	
COMMUNITY MEMORIAL HOME	ŀ
OSAKIS, MN 56360	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	(X5) DMPLETE DATE
document indicated NA-D very loudly stated the dining room should be open because R44 was hungry and wanted to eat. NA-D stated loudly to RN-C in front of R44, "in a disrespectful manner," then, "You can get him [R44] up when he lays down!" NA-D left R44 stiting in the hallway in his wheelchair and walked away, and RN-C assisted R44 to get a snack. The untilled document contained no further investigation regarding this incident with NA-D.  During interview on 11/19/14, at 2:24 p.m. RN-C stated NA-D was very disrespectful in front of R44 while they were in the hallway by the dining room on 11/3/14. RN-C stated after NA-D was being disrespectful in front of R44 while they were in the hallway by the dining room on 11/3/14. RN-C stated after NA-D was being disrespectful in front of R44 she reported it to the DON. On 11/3/14, NA-D, RN-C, and the DON had a meeting. RN-C stated NA-D was instructed by DON her attitude towards her supervisors needed to improve, and she needed to work on her ability to effectively communicate with her co-workers. RN-C was not aware of any further training or monitoring of NA-D, and did not remember if NA-D was spoke to specifically about being disrespectful in front of R44 and other residents.  During interview on 11/19/14, at 2:36 p.m. DON stated NA-D and admitted her actions on 11/3/14, were wrong and would not happen again. DON stated NA-D did not receive re-education or corrective action, was not being monitored with residents to ensure appropriate interactions, and there was no further investigation, nor had the incident been reported to the state agency. DON stated She did not feel this was reportable because R44 did not have any negative effects from this incident. Although NA-D had prior accusations of resident mistreatment, the facility did not follow up or monitor to prevent further resident abuse from occurring.  On the same untitled document dated 11/3/14,	

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AND DI AN OF CORRECTION INTEREST.		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
СОММИ	NITY MEMORIAL HON	ΛF	T MAIN STRE MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21850	written by RN-C regand resident mistre "What I felt as dem meal, stating rudely herself, even thoug more assistance to follow up with NA-D being rude to the reinterviews with staff who the resident was R47's Admission Rediagnoses of Alzhei incontinence. R47' 8/18/14, identified Fimpairment, was incompairment, was incompairment, was incompairment, was incompairment, was incompairment, and mobilition staff for toileting During interview on member (FM)-A staffive months ago, shinto the hallway while provided personal of R47 moaning, and on her. FM-A state curtain, and witness R47 on her side, ar with her elbow, while "Pain." FM-A stated she had the incident from the followed up with her overified FM-A had rean NA pressing down while a NA was hold with the nor side of the normal state of the normal	parding concerns with NA-D atment, indicated NA-D, eaning to a resident at noon that a resident could feed the this resident does need feed herself." There was no regarding RN-C concerns of sident. During multiple for no one was able to recall as NA-D had been rude to.  Decord dated 11/11/14, included mer's disease and urinary sequarterly MDS dated at the second management of the second management and personal hygiene.  11/18/14, at 11:19 a.m. family atted while visiting R47 about the stepped out of R47's room the stepped out of R47's room the two nursing assistants areas for R47. FM-A heard went into R47's room to check dishe pulled back the privacy sed an unidentified NA holding and the NA was leaning on R47 the FM-A felt was causing R47, dithis made her upset, and cident to SS-A right away. Indicated the nad anything about the facility, and no one had	21850			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HON	ΛF	T MAIN STRE MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21850	much about the incinvolved more in the the DON would have regarding the incide "Some of the things documented, and some of the things documented the had never between R47 and a causing her pain, and caused the the two stapported the two stapported the two stapported that they were long-time thingThe appear to be report no documentation of incident because, "resident." SS-A stated that they were long-time thingThe appear to be report no documentation of incident because, "resident." SS-A stated that they were long-time thingThe appear to be report no documentation of incident because, "resident." SS-A stated that they were long-time thingThe appear to be report no documentation of incident because, "resident." SS-A stated that they were long-time thingThe appear to be report no documentation of incident because, "resident." SS-A stated that they were long-time thingThe appear to be report no documentation of incident because, "resident." SS-A stated that they were long-time thingThe appear to be report no documentation of incident because, "resident." SS-A stated to the two stated that they were long-time thingThe appear to be report no documentation of incident because, "resident." SS-A stated to the two stated the transfer of the two stated that they were long-time thingThe appear to be report no documentation of incident because, "resident." SS-A stated to the two stated the transfer of the two stated that they were long-time thingThe appear to be report no documentation of incident because it was not mistreat the thingThe appear to be report no documentation of incident because it was not mistreat the administrator and the transfer of the two stated the transfer of	ident, because the DON was a investigation. SS-A stated to any documentation ant, however, SS-A stated, a reported [by family] are ome are not."  11/19/14, at 8:48 a.m., DON are heard about the incident a staff member leaning into her and had no idea what occurred.  Inview on 11/19/14, at 8:52 the now recalled she had not with R47 and the NA to a was gone that day, and a series wasn't a lot to itIt didn't able." SS-A stated there was a tree wasn't a lot to itIt didn't able." SS-A stated there was or investigation regarding the There was no injury to the red, "No form was filled out. The other to the did not know if it was in their ded to report the incident to it was not considered abuse. The employees personal file determined there was any 7.  11/19/14, at 9:00 a.m. DON colaint is received, the facility	21850			
		ncident, "To see if it's er receives the concern follows				

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00109 B. WING 11/24	1/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
410 WEST MAIN STREET	
COMMUNITY MEMORIAL HOME OSAKIS, MN 56360	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)    Comparison of the provider's plan of correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
up with the familyYou don't want to over reportIf you report everything, you could report four or five times a week." DON stated she would want to talk to the family, resident, and staff first if there is a grievance or concerns, and if there was a concern the nurse would do focus charting. DON verified there was no documentation regarding the reported grievance involving R47. The DON stated the facility protects a resident after a complaint by. "Watching the resident for reaction to that caregiver." DON verified no staff required monitoring in the last 7 months related to mistreatment of residents.  During interview on 11/19/14, at 11:42 a.m., the administrator was unable to clearly state if he was aware of the mistreatment allegation made by R47's family member. The administrator stated, "The policy says that I need to be made aware immediately. I don't think it was a report of injury" The administrator stated the facility looked at the grievance, and determined R47 did not experience any harm, so it didn't rise to the level of a reportable incident. Administrator stated when they had spoke about this incident, the facility felt because R47 was a heavier women, she was going to require "extra support" with cares, and he believed it was just a misunderstanding.  R12's Admission Record dated 1/18/08, included diagnoses of dementia, depressive disorder, and chronic kidney disease. R12's quarterly MDS dated 10/9/14, identified R12 had severe cognitive impairment, and required extensive staff assistance with all ADL's.  R12's care plan dated 10/20/14, directed staff to offer R12 toileting every two hours, with rounds at night, and PRN (as needed) per resident request.	

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE		
COMMU	NITY MEMORIAL HO	ИE	MAIN STRE	EET		
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	MN 56360	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
21850	Continued From pa	ge 70	21850			
	FM-B stated, "Som residents." FM-B s dementia, and som wants to go to the r her to the bathroom the bathroom, and stated she reported providing toileting fewell as the concern RN-D.  A facility Grievance	11/18/14, at 3:41 p.m. R12's e of the staff are rude to the tated R12 had the start of etimes she calls out and estroom, but staff will not take a and tell her she was just in the staff walk away. FM-B her concerns of staff not or R12 when requested, as s of rude staff members to //Complaint form dated FM-B had expressed				
	concerns regarding including staff being reminding her of the Documentation of F "Reminded staff to changes; spoke wit The grievance/com DON and registered	staff treatment of R12, g impatient with R12 when e last toileting activity. The facility Follow-up indicated, alert nurse of behavior h staff; passed on in report" plaint form was signed by d nurse RN-D, and there was tion of FM-B's complaints				
	unidentified visitor a they had overheard to use the restroom you that when I was be quiet!" The visit anyone at the facilit	11/18/14, at 11:45 a.m. an at the facility stated on 11/7/14, I R12 ask NA-J for assistance I. NA-J stated to R12, "I told is done, I would help you. Now or stated she had not told by about this, but stated this imfortable as she felt the staff				
	stated the reported mistreatment involv	11/21/14, at 10:07 a.m. DON incident/ grievance of staff ring R12, which was grievance form dated				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING	·····	11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
COMMI	NITY MEMORIAL HON	410 WEST	MAIN STRE	ET		
COMINO	NITT WEWORIAL HON	OSAKIS, I	MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21850	11/12/14, had not be administrator or the investigation of the any staff were interregarding toileting F.  During interview on stated if the facility mistreatment, it wor allegation to determ required reporting, and RN-B stated the fact which were mainly tears, grievance for for family complaint Problem/ Resolution if there were any constated she had not reports to the state and was not aware mistreatment to resusted specifically and those we "Misunderstandings RN-B stated if she is concerns with staff will talk to the staff and come to a concaccusation isn't documents."	een reported to the SA. DON had no incident, and could not verify if viewed or re-educated R12.  11/18/14, at 11:45 p.m. RN-B had an accusation of staffuld depend on the severity of nine the investigation, if it and if it would be documented. Eility had incident reports, used for falls or bruises/ skin ms, which could be filled out its, and also had forms called in forms, which could be used incerns involving staff. RN-B been involved in making any agency in the last 7 months,	21850	BEHOLINGT)		
	During a follow up in a.m., SS-A stated by have a lot of grieval grievance form if a kind. SS-A stated it would talk to the ad	nterview on 11/19/14, at 7:44 pically the facility doesn't nees, but staff can fill out the family had a concern of any f there was a grievance she ministrator and DON and talk involved. SS-A stated if after				

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-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HOI	ME	T MAIN STRE MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21850	the investigation the member had "done they would be suspresidents are prote investigation by, "Woomfort with that persidents are prote investigation by, "Woomfort with that persident investigation by in the facility immedia." So injured, the staff methe facility immedia. During follow up into a.m. DON stated a involved verbal or punknown origin we agency. DON state filled out by the nur receive the forms for staff will usually verconcerns. DON stated the resinvestigation of alle "Watching to see if behavior" The Doresidents in the past to monitor for behard allegations of staff stated the facility diallegations of staff documented, and settermined just by on the incident. Do no current system in place to in resident mistreat if any staff had a panot trained to use a set of the state of the provided in the position of the incident.	e facility determined the staff e something to the resident," bended. SS-A stated the cted during a facility Vatching the resident's level of erson [staff accused of S-A stated if the resident was ember would be removed from	21850			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 50.25			
		00109	B. WING	· · · · · · · · · · · · · · · · · · ·	11/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HOI	MI	T MAIN STRE MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21850	Continued From pa	age 73	21850			
	had multiple forms grievance forms, at DON stated some obinder in the social employee files, and her office. The DOI system to track resulting follow up into a.m. administrator involved in the investing at the investigate to the immediately, and resulting the DON about resulting investigate to the immediaters of the DON about resulting investigate to the immediaters of the DON about resulting investigate in the immediaters in the DON about resulting in the immediaters in the immediat	including incident reports, and problem/ resolution forms. of these forms were kept in a workers office, some were in a some were in a file cabinet in a verified the facility had no ident mistreatment.  Serview on 11/19/14, at 12:10 stated he felt like he was estigation process at the facility. Stated he would expect if there resident mistreatment, the sten to the complaint, evaluate extent warranted eport to him, "Accordingly." stated he communicated with ident incidents daily and				
	stated, "We communicate daily; we park in the same parking lot so we see each other at least twice a day." The administrator stated he believed the facility understood the process of investigation, reporting, and resident protection, however, not all allegations of mistreatment,					
	he was aware resic communication with desired by the resic staff are aware the administrator immeresident mistreatment.	he administrator also stated dents have felt that staffs he them have been, "Less then dent." The administrator stated need to report to the ediately any allegations of ent. He stated, "If it gets to level of mistreatment, we				
	report it [to the state verified no reports agency in past 4 m been a total of 3 re months, none of wh mistreatment to res stated they have a	e agency]." The administrator had been filed with the state onths, and there had only ports made in the last 8 nich had to do with staff sidents. The administrator very small facility, so the like they know there staff very				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COMMUNITY MEMORIAL HOME  410 WEST MAIN STREET  OSAKIS, MN 56360			EET			
()(1) ID	CHMMADV CTA	TEMENT OF DEFICIENCIES		DDOVIDED'S DI AN OE CODDECTIO	)N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MEMONI OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
21850	Continued From pa	ge 74	21850			
	their staff would mis	no reason to believe any of streat any of the residents.				
	state agency regard staff mistreatment f R12. The investiga	ding the above allegations of for R52, R58, R44, R47 and tions were submitted to the /21/14. Review of the				
	investigations submitted on 11/21/14, for R52, R58, R44, R47 and R12, were found to be incomplete and did not include interviews with any other staff regarding resident mistreatment by the staff members involved, did not include any					
	follow up interviews if the staff members mistreatment had a	s with family, nor did it indicate is accused of resident in prior accusations of DN was interviewed on				
	11/21/14, at approx incomplete investig agency on 11/21/14 R12. DON verified	imetly 2:10 p.m. regarding the gations submitted to the state I, for R52, R58, R44, R47 and the investigations were not				
	11/21/14, the facilting investigation and su	ubmitted amended s to the state agency for R52,				
	removed on 11/24/	on 11/19/14, at 4:19 p.m., was 14, at 1:07 p.m., when the ne following interventions:				
	prevention policy, w	d on the facility abuse which included specific on recognizing abuse and				
	beginning 11/21/14	packet was implemented , which included specific to report allegations of abuse				

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to the administrator and state agency. This

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	NT OF DEFICIENCIES OF CORRECTION					
		00109	B. WING		11/2	4/2014
	PROVIDER OR SUPPLIER	410 WEST	MAIN STRI	STATE, ZIP CODE EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21850	packet is available in the facility implements and the admir concerns residents.  All grievances or in reviewed by the DC on 11/19/14, the admir concerns residents in the facility implements are investigated by the DC on 11/19/14, the admir concerns residents.  Any grievances or in reviewed by the DC on 11/19/14, the admir concerns residents.  On 11/19/14, the admir concerns residents in the facility implements are investigation.  On 11/19/14, the admir concerns residents investigation.  On 11/19/14, from the investigation.  On 11/19/14, from the investigation in the facility potential mistreatmined in the facility plan.  The IJ was removed remained at a lower remained at a lower remained at a lower remained in the facility plan.	to all staff.  were educated on responsibility ons of abuse to the tate agency, and begin a	21850			

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STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			A. BUILDING.			
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HO	MIE	T MAIN STRE MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21850	Continued From pa	ige 76	21850			
	nursing (DON) could to ensure the abuse implemented as wr resident mistreatmer reported. The DON could perform audit to the state agency maltreatment.	of Correction: The director of Id work with the administrator e prohibiton policy is itten to ensure allegations of ent is investigated and N, administrator, or designee to ensure reports are made of allegations of reisdent				
	Time Period for Co	rrection: Fourteen (14) days				
22000	Subd. 14. Abuse facility, except hom personal care atten establish and enfor prevention plan. The assessment of the environment, and it factors which may and a statement of to minimize the risk comply with any rul promulgated by the (b) Each facility, agency and person providers, shall dever prevention plan for residing there or re The plan shall cont assessment of: (1) abuse by other indivulnerable adults; (1)	s population identifying encourage or permit abuse, specific measures to be taken of abuse. The plan shall es governing the plan				12/20/14

Minnesota Department of Health

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
СОММИ	NITY MEMORIAL HO	MI	T MAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	risk of abuse to the adults. For the pur term "abuse" includ (c) If the facility, and personal care knows that the vulr violent crime or an toward others, the plan must detail the minimize the risk threasonably be expefacility and persons unsupervised. Undo fa vulnerable adumisconduct or phy such information frauthority or through another facility, and	at person and other vulnerable poses of this paragraph, the	22000			
	by: Based on interview facility failed to represent agency, and istaff abuse, neglect 8 residents (R52, Finade allegations of failure of the facility place regarding all neglect, and mistre administrator and sthoroughly investig	ent is not met as evidenced  and document review, the ort to the administrator and nvestigate, all allegations of it, and/ or mistreatment for 5 of R58, R44, R47 and R12) who if staff maltreatment. The if to ensure a system was in allegations of staff abuse, eatment were reported to the state agency, and were ated, resulted in an Immediate I 36 residents currently		Corrected		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00109	B. WING		11/	24/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
COMMU	NITY MEMORIAL HON	ΛF	T MAIN STRE	ET		
	I	OSAKIS,	MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
22000	residing in the facilit The IJ began on 11 facility failed to report the administrator are and implement interwere protected from residents were free administrator and doutified of the immeresidents in the facility was removed noncompliance remand severity level, which is a severity level,	ty. /19/14, at 4:19 p.m., when the				
	nurse (RN) case may facility had spoke to During another inte R52 again shared h	anager, but no one from the other about the incident.  rview on 11/8/14, at 2:53 p.m. per concerns of rough aff member during a transfer,				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		410 WFS	T MAIN STRE			
COMMU	NITY MEMORIAL HON	ME OSAKIS,	MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 79	22000			
	when he assisted h it was like to be in p not provided cares she would, "Shy aw provide cares to he	ight the NA was too rough er and didn't understand what pain. R52 stated the NA had to her since this incident, but ray," from that NA if he were to r again due to the pain he ast time he assisted her to				
	stated she was awa male NA transferrin spoken with both R incident. The DON made to the SA or a allegation, and there	11/18/14, at 3:35 p.m. DON are of R52's allegation of a g her roughly, and she had 52 and the NA about the confirmed no report had been administrator regarding the e was no documented nining what had happened.				
	service (SS)-A and regarding R52's con the NA. SS-A stated and reported R52 w treatment by staff d she had talked to the incident, howev documented the invision of the interest this to the state age and DON stated the incident, and the any injury, so they comet the definition of mistreatment, and to be made to the s stated there was not investigation or interest accused of rough tr	11/18/14, at 6:29 p.m. social the DON were interviewed implaint of rough treatment by d R52's family had called her was upset about rough uring a transfer. SS-A stated in the NA and charge nurse about er, SS-A stated she had not westigation regarding the views, and she did not report ency or administrator. SS-A by had spoken with R52 about the resident did not experience didn't believe the allegation of potential abuse, neglect, or determined no report needed tate agency. SS-A and DON of documentation regarding any rviews, and the NA who was eatment of R52 had no further ing to ensure further resident of occur.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY. S	TATE, ZIP CODE		
0014141	NITY MEMORIAL LION	410 WFS	MAIN STRE			
СОММО	NITY MEMORIAL HON	OSAKIS, I	MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 80	22000			
	stated she was awa month ago regardin a NA. RN-B stated completed with the R52 roughly, as we documented any of reported R52's accu the administrator or feel this met the de- mistreatment that n administrator or sta- not experience any	11/18/14, at 3:27 p.m. RN-B are R52 had concerns about a 19 being transferred roughly by interviews had been NA accused of transferring II as with R52, but she had not the investigation, nor had she usation of rough treatment to 2 state agency. RN-B did not finition of resident eeded to be reported to the 19 te agency because R52 did 19 injury, and RN-B felt it was 2 standing between R52 and				
	administrator stated would be handled a would work with the and would only be r it rose to the level of an injury resulted from administrator was used the allegation of immediately after it stated he knew the transfer with R52, a would intentionally required assistance eating.  Review of a facility	11/19/14, at 12:13 p.m. the drough transfers of a resident is a complaint and facility staff of family to resolve the concern, reported to the state agency if if mistreatment, for example, if om the rough transfer. The insure if he was made aware the rough transfer with R52 had happened, however, he NA accused of the rough and he did not believe the NA mistreat a resident.  S dated 10/2/14, indicated inpaired cognition, and with all ADL's, including  Problem Resolution form atted R58 was eating in the				
	dining room and NA "You have to eat, th	A-D was overheard telling R58, ere is nothing in your mouth on why you won't eat!" NA-D				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION    X1   PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   11/24/2014	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  410 WEST MAIN STREET OSAKIS, MN 56360   [X4) ID PREFIX ITAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) WIST BE PRECEDED BY FULL TAG  CONTINUED FROM INSTREED OSAKIS, MN 56360  [EACH DEFICIENCY WIST BE PRECEDED BY FULL TAG  CONSTRUCTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  22000 Continued From page 81  22000 Was observed by NA-I grabbing R58's cheeks, pinching them together so her mouth would open, and pushed a spoon through R58's lips, and stated, "Now eat!" NA-I reported the incident to licensed practical nurse (LPN)-B, who then reported it to RN-B. The documentation on the bottom of the Problem Resolution form indicated, "Above issue was reviewed with [NA-D] on 88'8'14, by the RN case manager. [NA-D] stopped in DON office on 8'111'41, at 1:30 p.m. RN-B stated she remembered the incident between R58 and NA-D. RN-B stated NA-D had apologized and recognized she was wrong to treat R58 the way she did, so the facility felt there was nothing further they needed to do. RN-B stated she had no further investigation of the administrator or state agency because they did not believe there was any abuse that took place, the resident did not experience any injury, and	
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stated she remembered the incident between R58 and NA-D. RN-B stated NA-D had apologized and recognized she was wrong to treat R58 the way she did, so the facility felt there was nothing further they needed to do. RN-B stated she had no further investigation of the incident, and it was not reported to the administrator or state agency because they did not believe there was any abuse that took place, the resident did not experience any injury, and	
R58 and NA-D. RN-B stated NA-D had apologized and recognized she was wrong to treat R58 the way she did, so the facility felt there was nothing further they needed to do. RN-B stated she had no further investigation of the incident, and it was not reported to the administrator or state agency because they did not believe there was any abuse that took place, the resident did not experience any injury, and	
apologized and recognized she was wrong to treat R58 the way she did, so the facility felt there was nothing further they needed to do. RN-B stated she had no further investigation of the incident, and it was not reported to the administrator or state agency because they did not believe there was any abuse that took place, the resident did not experience any injury, and	
treat R58 the way she did, so the facility felt there was nothing further they needed to do. RN-B stated she had no further investigation of the incident, and it was not reported to the administrator or state agency because they did not believe there was any abuse that took place, the resident did not experience any injury, and	
was nothing further they needed to do. RN-B stated she had no further investigation of the incident, and it was not reported to the administrator or state agency because they did not believe there was any abuse that took place, the resident did not experience any injury, and	
stated she had no further investigation of the incident, and it was not reported to the administrator or state agency because they did not believe there was any abuse that took place, the resident did not experience any injury, and	
incident, and it was not reported to the administrator or state agency because they did not believe there was any abuse that took place, the resident did not experience any injury, and	
administrator or state agency because they did not believe there was any abuse that took place, the resident did not experience any injury, and	
not believe there was any abuse that took place, the resident did not experience any injury, and	
the resident did not experience any injury, and	
B58 nag no ongoing effects from the incident	
· · · · · · · · · · · · · · · · · · ·	
R44's annual MDS dated 10/2/14, indicated the	

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Minnesota Department of Health

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	DENTIFICATION NUMBER:	A. BUILDING:			LETED
		00109	B. WING		11/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		410 WEST	MAIN STRE	ET		
COMMU	NITY MEMORIAL HON	OSAKIS, I	MN 56360			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
				DEFICIENCY)		
22000	Continued From pa	ge 82	22000			
	disease, had mode	rately impaired cognition, and				
		of one staff with activities of				
	daily living (ADL's),	and set up assistance with				
	meals.					
		d an untitled document, which				
		N's office, indicating on				
		ght R44 to the dining room in the dining room was not				
		st yet. The untitled document				
		y loudly stated the dining room				
		cause R44 was hungry and				
		D stated loudly to RN-C in				
		isrespectful manner," then,				
		R44] up when he lays down!"				
		g in the hallway in his				
	R// to get a spack	ked away, and RN-C assisted The untitled document				
		r investigation regarding this				
	incident with NA-D.	i iiivooligalioii rogaraiiig liiio				
		11/19/14, at 2:24 p.m. RN-C				
		ery disrespectful in front of				
		e in the hallway by the dining				
		RN-C stated after NA-D was				
		in front of R44 she reported it -3-14, NA-D, RN-C, and DON				
		-3-14, NA-D, RN-C, and DON -C stated NA-D was instructed				
		e towards her supervisors				
		and she needed to work on				
		ely communicate with her				
		vas not aware of any further				
		ng of NA-D, and did not				
		was spoke to specifically				
		pectful in front of R44 or other				
	residents.	11/10/14 at 2:26 a.m. tha				
		11/19/14, at 2:36 p.m. the nad admitted her actions on				
		g and would not happen again.				
		did not receive re-education or				
		as not being monitored with				

Minnesota Department of Health

residents to ensure appropriate interactions, and

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
COMMU	NITY MEMORIAL HON	Λ <b>F</b>	「MAIN STRE VIN 56360	EET		
(VA) ID	CHMMADV CTA	TEMENT OF DEFICIENCIES		DDOVIDED'S DI ANI CE CODDECTIO	- N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 83	22000			
	incident been report administrator. DON was reportable becamegative effects from had prior accusation the facility did not for further resident about On the same untitle written by RN-C regard resident mistre "What I felt as demined, stating rudely herself, even though more assistance to follow up with NA-D being rude to the reproviding necessary interviews with staff who the resident was not r	r investigation, nor had the ted to the state agency or I stated she did not feel this ause R44 did not have any m this incident. Although NA-D ns of resident mistreatment, ollow up or monitor to prevent use from occurring. It document dated 11/3/14, garding concerns with NA-D atment, indicated NA-D was, eaning to a resident at noon that a resident could feed this resident does need feed herself." There was not regarding RN-C concerns of esident or possible neglect of y care. During multiple in no one was able to recall as NA-D had been rude to out reported to the state agency did there was no further				
	diagnoses of Alzhei incontinence. R47's 8/18/14, identified F impairment, was inc bladder, required ex	ecord dated 11/11/14, included mer's disease and urinary s quarterly MDS dated R47 had severe cognitive continent of bowel and ktensive assistance of two y, and was totally dependent				
	on staff for toileting During interview on stated while visiting she stepped out of while two nursing a cares for R47. FM- went into R47's roo stated she pulled ba	and personal hygiene.  11/18/14, at 11:19 a.m. FM-A R47 about five months ago, R47's room into the hallway ssistants provided personal A heard R47 moaning, and m to check on her. FM-A ack the privacy curtain, and ntified NA holding R47 onto				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

O0109

NAME OF PROVIDER OR SUPPLIER

COMMUNITY MEMORIAL HOME

Minnesota Department of Health

(X2) MULTIPLE CONSTRUCTION
A. BUILDING:
B. WING
B. WING
TI1/24/2014

STREET ADDRESS, CITY, STATE, ZIP CODE
410 WEST MAIN STREET
OSAKIS, MN 56360

сомми	NITY MEMORIAL HOME	T MAIN STREI MN 56360	ET	
(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) COMPLETE DATE
22000	Continued From page 84	22000		
	her side, and was leaning onto R47 with her elbow, which she felt was causing R47, "Pain." FM-A stated this made her upset, and she reported the incident to social services (SS)-A right away. FM-A stated she had not heard anything about the incident from the facility, and no one had followed up with her regarding her concerns of staff mistreatment of R47.			
	During interview on 11/19/14, at 7:44 a.m. SS-A verified FM-A had reported an incident involving a NA pressing down with her elbow into R47, while a NA was holding R47 on her side during personal cares. SS-A stated she did not know much about the incident, because the DON was involved more in the investigation. SS-A stated the DON would have any documentation regarding the incident, however, SS-A stated, "Some of the things reported [by family] are documented, and some are not."			
	During interview on 11/19/14, at 8:48 a.m. DON stated she had never heard about the incident between R47 and a staff member leaning into her causing her pain, and had no idea what occurred.			
	During follow up interview on 11/19/14, at 8:52 a.m. SS-A stated she now recalled she had reported the incident with R47 and the NA to RN-A because DON was gone that day, and RN-A was in charge. SS-A stated she and RN-A talked to the two staff members involved in providing R47 cares that day, and, "They [the staff] did not feel that they were being roughIt was a one-time thingThere wasn't a lot to itIt didn't appear to be reportable." SS-A stated there was no documentation or investigation regarding the incident because, "There was no injury to the resident." SS-A stated, "No form was filled out.			
	resident." SS-A stated, "No form was filled out. This incident was not reportable." SS-A stated			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
-	PROVIDER OR SUPPLIER	410 WES	DRESS, CITY, S T MAIN STRE MN 56360	TATE, ZIP CODE E <b>ET</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	she did not report the administrator, and opolicy that she need the administrator if SS-A could not reca accused of being ronothing would be in because it was not mistreatment to R4 the state agency or During interview on stated when a company should review the ir reportablewhoeve up with the family reportIf you report four or five times a want to talk to the fathere is a grievance a concern the nurse DON verified there regarding the report The DON stated the after a complaint by reaction to that care required monitoring mistreatment of resulting interview on administrator was a ware of the mistre R47's family memb "The policy says the immediately. I don't injury" The administrator any level of a reportable in the policy says the immediately. I don't injury" The administrator any level of a reportable in the policy says the immediately. I don't injury"	ne incident to the did not know if it was in their ded to report the incident to it was not considered abuse. All who the employees were bugh with R47, and stated the employees personal file determined there was any 7. This was not reported to administrator.  11/19/14, at 9:00 a.m. DON colaint is received, the facility incident, "To see if it's er receives the concern follows You don't want to over the everything, you could report week." DON stated she would amily, resident, and staff first if the or concerns, and if there was the would do focus charting. Was no documentation the grievance involving R47. The facility protects a resident for egiver." DON verified no staff in the last 7 months related to				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
СОММИ	NITY MEMORIAL HO	ME	T MAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
22000	the facility felt becawomen, she was gowith cares, and he misunderstanding.  R12's Admission Ridiagnoses of demechronic kidney disedated 10/9/14, idencognitive impairment assistance with all with the factor of th	use R47 was a heavier believed it was just a ecord dated 1/18/08, included ntia, depressive disorder, and ase. R12's quarterly MDS tified R12 had severent, and required extensive staff ADL's.  ted 10/20/14, directed staff to every two hours, with rounds at needed) per resident request.  11/18/14, at 3:41 p.m. R12's e of the staff are rude to the tated R12 had the start of etimes she calls out and estroom, but staff will not take and tell her she was just in the staff walk away without a stated she reported her of providing toileting for R12 well as the concerns of rude N-D.  /Complaint form dated FM-B had expressed a staff treatment of R12, g impatient with R12 when e last toileting activity. The facility Follow-up indicated, alert nurse of behavior the staff; passed on in report" plaint form was signed by d nurse RN-D, and there was tion of FM-B's complaints	22000			

Minnesota Department of Health

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Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
COMMU	NITY MEMORIAL HO	ИF	MAIN STRE	EET		
	T	OSAKIS, I				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 87	22000			
	unidentified visitor at they had overheard to use the restroom you that when I was be quiet!" The visit anyone at the facilit had made her uncowere very rude.  During interview on stated the reported mistreatment involved documented on the 11/12/14, had not be administrator or the investigation of the any staff were interview of the staff were interview on the sta	11/18/14, at 11:45 a.m. an at the facility stated on 11/7/14, I R12 ask NA-J for assistance a. NA-J stated to R12, "I told as done, I would help you. Now or stated she had not told by about this, but stated this comfortable as she felt the staff of 11/21/14, at 10:07 a.m. DON incident/ grievance of staff ring R12, which was a grievance form dated been reported to the a SA. DON had no incident, and could not verify if viewed or re-educated R12 and being rude to the				
	stated if the facility mistreatment, it wo allegation to determ required reporting, RN-B stated the fact which were mainly tears, grievance for for family complaint Problem/ Resolutio if there were any constated she had not reports to the state last 7 months, and staff mistreatment to asked specifically and R52, R58, R12, R4	11/18/14, at 11:45 p.m. RN-B had a accusation of staff uld depend on the severity of nine the investigation, if it and if it would be documented. cility had incident reports, used for falls or bruises/ skin rms, which could be filled out ts, and also had forms called n forms, which could be used oncerns involving staff. RN-B been involved in making any agency or administrator in the was not aware accusations to residents. When RN-B was about the incidents involving 7 and R44, RN-B stated she incidents, but there was no				

Minnesota Department of Health

AND BLANCE CORRECTION INDENTIFICATION NUMBER:	2) MULTIPLE CONSTRUCTION BUILDING:	(X3) DATE SURVEY COMPLETED
00109 B. W	WING	11/24/2014
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME  STREET ADDRES  410 WEST MA OSAKIS, MN S		
	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
injury and those were considered more, "Misunderstandings" then actual mistreatment which would require a report to the SA. RN-B stated if she is made aware of any concerns with staff and resident interaction, she will talk to the staff and get their side of the story, and come to a conclusion. RN-B stated every accusation isn't documented because usually it is a personality conflict or a misunderstanding.  During a follow up interview on 11/19/14, at 7:44 a.m., SS-A stated typically the facility doesn't have a lot of grievances, but staff can fill out the grievance form if a family had a concern of any kind. SS-A stated if there was a grievance she would talk to the administrator and DON and talk to the staff member involved. SS-A stated if after the investigation the staff member would be suspended if the facility determined they had "done something to the resident." SS-A stated the residents are protected during a facility investigation by, "Watching the resident's level of comfort with that person [staff accused of mistreatment]." SS-A stated if the resident was injured, the staff member would be removed from the facility immediately.  During follow up interview on 11/19/14, at 8:48 a.m. DON stated any type of incident that involved verbal or physical abuse, or injuries of unknown origin, were reportable to the state agency. DON stated the grievance forms are filled out by the nurses, and she doesn't usually receive the forms from the staff, however, the staff will usually verbally inform her of any concerns. DON stated the nurses will usually get together and talk to determine if the incident is reportable, and if the resident had any injury's.  DON stated the resident is protected during an	2000	

Minneso	<u>ota Department of He</u>	alth				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00109	B. WING		11/0	4/2014
		00109			11/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		410 WES <sup>7</sup>	T MAIN STRE	EET		
COMMUI	NITY MEMORIAL HO	VIE OSAKIS, I	MN 56360			
(X4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
22000	Continued From pa	iae 89	22000			
		-				
ļ		there is any changes in			ļ	
ļ		ON stated there were no			ļ	
	·	st 8 months they needed to				
ļ		or changes related to			ļ	
ļ		mistreatment. The DON			ļ	
ļ		d not feel everything related to			ļ	
		mistreatment needed to be				
		some things could be				
		checking with a staff member				
		ON acknowledged there was				
ļ		to ensure all allegations were			ļ	
		ne state agency and				
ļ		thoroughly investigated, nor			ļ	
		in place to track and trend				
ļ		sident mistreatment allegations			ļ	
ļ		staff had a pattern. DON of trained to use a specific			ļ	
ļ		concerns of resident			ļ	
ļ					ļ	
		the facility had multiple forms eports, grievance forms, and				
ļ		forms. DON stated some of			ļ	
	•	ept in a binder in the social				
		ne were in employee files, and				
		cabinet in her office. The				
		icility had no system to track				
		ent or to ensure all allegations	!			
		tment were reported to the	!			
	administrator and S		!			
	dammetrator and c	,				
	During follow up int	terview on 11/19/14, at 12:10				
		stated he felt like he was				
		stigation process at the facility.	!			
		stated he would expect if there				
		resident mistreatment, the	!			
		sten to the complaint, evaluate	!			
	it, investigate to the		!			
		eport to him, "Accordingly."	!			
		stated he communicated with				
		ident incidents daily and				
		unicate daily; we park in the				

Minnesota Department of Health

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00109	B. WING		11/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
СОММИ	NITY MEMORIAL HO	VIE	T MAIN STRI MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
22000	twice a day." The abelieved the facility investigation, report however, not all alle "Result in injury." The was aware reside communication with desired by the resident mistreatmen, if it rises to the report it [to the state verified no reports I agency in past 4 mbeen a total of 3 remonths, none of whistreatment to resistated they had a vigiliary management feels well, and they have their staff would mistreatment to resistate agency regard staff mistreatment in R12. The investigations submit R58, R44, R47 and incomplete and did any other staff members follow up interviews if the staff members mistreatment had a resident abuse. D0 11/21/14, at approximations and mistreatment had a resident abuse.	ge 90  of we see each other at least administrator stated he understood the process of ting, and resident protection, egations of mistreatment, he administrator also stated lents have felt that staffs in them have been, "Less then dent." The administrator stated need to report to the diately any allegations of ent. He stated, "If it gets to level of mistreatment, we er agency]." The administrator had been filed with the state on this, and there had only corts made in the last 8 hich had to do with staff sidents. The administrator ery small facility, so like they know their staff very no reason to believe any of estreat any of the residents.  cility submitted reports to the ding the above allegations of for R52, R58, R44, R47 and attions were submitted to the (21/14. Review of the not include interviews with arding resident mistreatment by except any prior accusations of DN was interviewed on imetly 2:10 p.m. regarding the gations submitted to the state				

Minnesota Department of Health

STATE FORM 6899 TNOZ11 If continuation sheet 91 of 93

11/24/2014

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

00109 B. WING \_\_\_\_\_

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

COMMUN	NITY MEMORIAL HOME	TMAIN STRE VIN 56360	ET	
(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) COMPLETE DATE
22000	Continued From page 91	22000		
	agency on 11/21/14, for R52, R58, R44, R47 and R12. DON verified the investigations were not complete and lacked the above information. On 11/21/14, the facility completed further investigation and submitted amended investigation reports to the state agency for R52, R58, R44, R47 and R12.			
	The IJ that began on 11/19/14, at 4:19 p.m., was removed on 11/24/14, at 1:07 p.m., when the facility completed the following interventions:			
	All staff were trained on the facility abuse prevention policy, which included specific instruction to staff on recognizing abuse and neglect.			
	All prior incidents involving R52, R58, R44, R47 and R12 were reported to the state agency and thouroughly investigated.			
	An abuse protocol packet was implemented beginning 11/21/14, which included specific instructions on how to report allegations of abuse to the administrator and state agency, as well as a checklist on completing an investigation after the report is made to the administrator and SA. This packet is available to all staff.			
	All charge nurses were educated on responsibility to report all allegations of abuse to the administrator and state agency, and begin a documented investigation.			
	All final investigations will be completed by the DON and reviewed with the administrator.			
	All residents in the facility were interviewed by SS-A and the administrator regarding any further concerns residents had with staff mistreatment.			

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

O0109

MAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

(X2) MULTIPLE CONSTRUCTION
A. BUILDING:
A. BUILDING:
B. WING

11/24/2014

COMMUNITY MEMORIAL HOME 410 WEST MAIN STREET OSAKIS, MN 56360				
(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) COMPLETE DATE
22000	Continued From page 92	22000		
	The facility implemented a log to track and trend grievances.			
	Any grievances or incident reports will be reviewed by the DON and administrator daily.			
	On 11/19/14, the administrator developed a memo sent to all staff which indicated any employee accused/ involved in a resident mistreatment investigation will be immediately suspended from work, pending the outcome of the investigation.			
	On 11/24/14, from 12:00 p.m. to 12:30 p.m., direct staff were interviewed and explained their responsibility for identification of incidents of potential mistreatment, internal reporting; resident protection, investigation and external reporting as defined in the facility's revised Abuse Prevention Plan.			
	The IJ was removed, but non compliance remained at a lower scope/ severity of a F level, widespread with no actual harm but potential for harm.			
	Suggested Method of Correction: The director of nursing (DON) and administrator could review the abuse prohibiton policy to ensure it is being implemented to include all allegations of staff mistreatment were reported to the state agency and administrator. The DON or designee could perform audits to ensure reports to the state agency and administrator occurred in the requried timeframes.			
	Time Period for Correction: Fourteen (14) days			

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