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

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245465**

2. STATE VENDOR OR MEDICAID NO. (L2) **668340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COMMUNITY MEMORIAL HOME**
(L4) **410 WEST MAIN STREET**
(L5) **OSAKIS, MN** (L6) **56360**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **1/14/2015** (L34)

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

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

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

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

* Code: **A, 5*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mary Rogers, HPR Social Work Specialist 1/14/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 02/13/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **04/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **01/23/2015** (L33)

DETERMINATION APPROVAL

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.

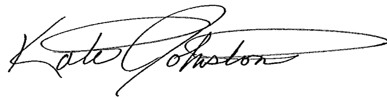
If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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

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

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))

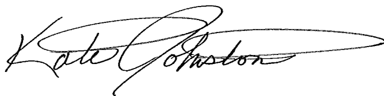
The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

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

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245465	A. Building B. Wing	1/14/2015

Name of Facility	Street Address, City, State, Zip Code
COMMUNITY 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0224** Reg. # **483.13(c)** LSC	**12/18/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	**12/18/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**12/18/2014**
ID Prefix **F0241** Reg. # **483.15(a)** LSC	**12/18/2014**	ID Prefix **F0257** Reg. # **483.15(h)(6)** LSC	**12/15/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	**12/18/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	**12/19/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	**12/18/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	**12/12/2014**
ID Prefix **F0325** Reg. # **483.25(i)** LSC	**12/18/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	**12/16/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	**12/11/2014**
ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	**12/05/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	**12/16/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	**12/05/2014**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	1/28/2015	29437	1/14/2015
CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245465	A. Building B. Wing	1/14/2015

Name of Facility	Street Address, City, State, Zip Code
COMMUNITY 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0465 Reg. # 483.70(h) LSC	12/16/2014	ID Prefix F0490 Reg. # 483.75 LSC	12/18/2014	ID Prefix F0493 Reg. # 483.75(d)(1)-(2) LSC	12/18/2014
ID Prefix F0501 Reg. # 483.75(i) LSC	12/18/2014	ID Prefix F0514 Reg. # 483.75(l)(1) LSC	12/18/2014	ID Prefix F0520 Reg. # 483.75(o)(1) LSC	12/18/2014

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	1/28/2015	29437	1/14/2015
CMS RO				

Followup to Survey Completed on: 11/24/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

AH Form Approved

1/22/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00109	A. Building B. Wing	1/14/2015

Name of Facility	Street Address, City, State, Zip Code
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20255** Reg. # **MN Rule 4658.0070** LSC	**12/18/2014**	ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp. 4** LSC	**12/18/2014**	ID Prefix **20625** Reg. # **MN Rule 4658.0450 Subp. 1 A-I** LSC	**12/18/2014**
ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	**12/19/2014**	ID Prefix **20920** Reg. # **MN Rule 4658.0525 Subp. 6 B** LSC	**12/18/2014**	ID Prefix **20965** Reg. # **MN Rule 4658.0600 Subp. 2** LSC	**12/18/2014**
ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp. 7** LSC	**12/11/2014**	ID Prefix **21230** Reg. # **MN Rule 4658.0700 Subp. 2 B** LSC	**12/18/2014**	ID Prefix **21385** Reg. # **MN Rule 4658.0800 Subp. 3** LSC	**12/05/2014**
ID Prefix **21525** Reg. # **MN Rule 4658.1305 A.B.C** LSC	**12/05/2014**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	**12/16/2014**	ID Prefix **21540** Reg. # **MN Rule 4658.1315 Subp. 2** LSC	**12/16/2014**
ID Prefix **21665** Reg. # **MN Rule 4658.1400** LSC	**12/16/2014**	ID Prefix **21705** Reg. # **MN Rule 4658.1415 Subp. 6** LSC	**12/15/2014**	ID Prefix **21805** Reg. # **MN St. Statute 144.651 Subd. 5** LSC	**12/18/2014**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	1/28/2015	24937	1/14/2015
CMS RO				

AH Form Approved

1/22/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00109	A. Building B. Wing	1/14/2015

Name of Facility	Street Address, City, State, Zip Code
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **21850** Reg. # **MN St. Statute 144.651 Subd. 1** LSC	Correction Completed **12/18/2014**	ID Prefix **22000** Reg. # **MN St. Statute 626.557 Subd.** LSC	Correction Completed **12/18/2014**		

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	1/28/2015	1/28/2015	24937	1/14/2015

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/24/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: TNOZ
Facility ID: 00109

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2. STATE VENDOR OR MEDICAID NO. (L2) **668340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COMMUNITY MEMORIAL HOME**
(L4) **410 WEST MAIN STREET**
(L5) **OSAKIS, MN** (L6) **56360**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **11/24/2014** (L34)

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

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

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 CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **B,5*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Holly Kranz, HFE NE II 12/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 01/23/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **04/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **01/23/2015** (L33)

DETERMINATION APPROVAL

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.

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

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:

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

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

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

Substandard Quality of Care - 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;

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

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

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

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

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. <u>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.</u>

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A survey was conducted by the Minnesota Department of Health from November 17, 2014 through November 24, 2014. The survey resulted in an Immediate Jeopardy (IJ) at F224 and F225 related to the facility's failed to comprehensively assess, investigate, report allegations of abuse to the administrator and state agency and implement interventions to ensure residents were free from abuse which resulted in the high potential for harm or death. The facility was notified of the immediate jeopardy on Novermber 19 2014, at 4:19 p.m. The IJ began November 19, 2014, at 4:19 p.m. and was removed on November 24, 2014 at 1:07 p.m. but noncompliance remained at a pattern scope and severity level, with potential for actual harm. An extended survey was conducted by the Minnesota Department of Health on November 20 and 21, 2014. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 224 SS=L	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN	F 224		12/18/14

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

Electronically Signed — 12/20/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 224	Continued From page 1 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility 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. The immediate jeopardy began on 11/19/14, at 4:19 p.m. when the facility failed to comprehensively assess, investigate, and implement interventions to ensure residents who were involved in alleged incidents of staff mistreatment, were free from staff abuse. On 11/19/14, at 4:19 p.m. the administrator and director of nursing (DON) were notified of the immediate jeopardy (IJ) for all 36 residents currently residing in the facility. The IJ was removed on 11/24/14, at 1:07 p.m. but noncompliance remained at a widespread scope	F 224	F224- Vulnerable adult reports were filed to the state agency on residents #47 and #12 on 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 filed 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 further training on resident transfers and one employee required additional dementia education. The two employees that received further education were allowed to return to work after the education had been completed. All above residents affected had care plans reviewed. No adjustments were required. Mood/behavior focus charting was initiated and completed on all residents #52, 58, 44, 47 and 12 to monitor for any changes in psychosocial wellbeing. No concerns or effects from the filed reports were noted.	

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F 224	Continued From page 2 and severity level, with potential for actual harm. Findings include: R52's Face Sheet dated 11/20/14, identified diagnoses including hip joint replacement, scoliosis, and pain in the pelvic region and thigh. R52's quarterly Minimum Data Set (MDS) dated 10/23/14, identified R52 had no cognitive impairment and required extensive weight bearing assistance from two staff for transfers. During interview on 11/17/14, at 3:34 p.m. R52 stated a few weeks ago, a male nursing assistant (NA) grabbed her on the arm during a transfer from the wheelchair to the bed, and was so rough she hit her hip on the nightstand table. R52 stated she, "Hollered and screamed from the pain," because the transfer was so rough. R52 stated she reported the incident to the registered nurse (RN) case manager, but no one from the facility had spoken to her about the incident. During another interview on 11/8/14, at 2:53 p.m. R52 again shared her concerns of rough treatment from a staff member during a transfer, and stated she thought the NA was too rough when he assisted her and didn't understand what it was like to be in pain. R52 stated the NA had not provided cares to her since this incident, but she would, "Shy away," from that NA if he were to provide cares to her again due to the pain he caused during the last time he assisted her to transfer. During interview on 11/18/14, at 3:35 p.m. DON stated she was aware of R52's allegation of a male NA transferring her roughly, and she had	F 224	Interviews conducted with all nursing staff on 11/19/14 and interviews conducted with all residents in the facility on 11/20/14 to identify other potential cases of resident neglect or mistreatment. During resident interviews, one incident was reported. Incident was immediately reported to state agency. The incident was then investigated per Vulnerable Adult Policy and procedures. Staff member involved was suspended and received additional training on transfers prior to her return to work schedule. Safety Risk assessments were completed on all residents and care plan changes were adjusted. Zero Tolerance statement initiated by facility administrator. Vulnerable Adult Policy and Procedure was reviewed and revised to include the protection of residents during an alleged act of abuse/neglect. Changes include immediate removal and/or suspension of alleged perpetrator. All licensed staff received training and direction on how to submit an alleged report of abuse to the state agency. An in-service training by a trained consultant was conducted for staff on Vulnerable Adult and Abuse. This education included reviewing the hard copy of the updated Vulnerable Adult Abuse and Prevention Plan, an in-depth discussion on different types of abuse including examples of physical, verbal, and emotional abuse. The staff were also educated on the new disciplinary procedures during reports of alleged abuse. The new Abuse Protocol folders were also reviewed and the contents of	

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F 224	Continued From page 3 spoken with both R52 and the NA about the incident. The DON confirmed no report had been made to the SA regarding the allegation, The administrator was not notified immediately of the allegation, and there was no documented investigation determining what had happened. During interview on 11/18/14, at 6:29 p.m. social service (SS)-A and the DON were interviewed regarding R52's complaint of rough treatment by the NA. SS-A stated R52's family had called her and reported R52 was upset about rough treatment by staff during a transfer. SS-A stated she had talked to the NA and charge nurse about the incident, however, SS-A stated she had not documented the investigation regarding the findings of the interviews, and she did not report this to the state agency or administrator. SS-A and DON stated they had spoken with R52 about the incident, and the resident did not experience any injury, so they didn't believe the allegation met the definition of potential abuse, neglect, or mistreatment, and determined no report needed to be made to the state agency. SS-A and DON stated there was no documentation regarding any investigation or interviews, and the NA who was accused of rough treatment of R52 had no further training or monitoring to ensure further resident mistreatment did not occur. During interview on 11/18/14, at 3:27 p.m. RN-B stated she was aware R52 had concerns about a month ago regarding being transferred roughly by a NA. RN-B stated interviews had been completed with the NA accused of transferring R52 roughly, as well as with R52, but she had not documented any of the investigation, nor had she reported R52's accusation of rough treatment to the administrator or state agency. RN-B was not	F 224	them were discussed at the inservice. The director of nursing conducted 2 staff meetings to review Vulnerable Adult policy and procedures. Policy and Procedures of Morning Standup, Weekly IDT, and Quality Assurance were reviewed and revised to include added communication and review of incidents and Vulnerable Adult trends. Grievances and or incidents will be reviewed on a daily basis during the Morning Standup Meeting and weekly with the IDT team. All unresolved grievances will be reviewed quarterly with the QA team for further review and direction for resolution. An incident log was developed and put into place by the Director of Nursing. All incidents will be reviewed during Morning Standup and then the incident will be placed on the log record. The log will be reviewed weekly during IDT and quarterly with QA to assure that all incidents are fully investigated and complete. A new grievance form was developed and put onto place. Staff were educated by the director of nursing on the location and proper use of the new facility grievance forms. Staff education of Vulnerable Adult Policy and Procedure will continue through QAPI. During resident council on 12/18/14, a review of Vulnerable Adult Policy and Procedure and grievance procedure took place. All IDT weekly log minutes will be reviewed quarterly with the QA team to review incidents and potential trends of abuse. Upon this review system	

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COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET** **OSAKIS, MN 56360**

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F 224	Continued From page 4 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 intentionally mistreat a resident. R58's quarterly MDS dated 10/2/14, indicated R58 had severely impaired cognition, and required assistance with all ADL's, including eating. Review of a facility Problem Resolution form dated 8/7/14, indicated R58 was eating in the dining room and NA-D was overheard telling R58, "You have to eat, there is nothing in your mouth so there is no reason why you won't eat!" NA-D 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 8/8/14, by the RN case manager. [NA-D] stopped in DON office on 8/11/14, to apologize for the	F 224	revisions and/or staff education will be implemented indicated via proscribed written action plan. New employee hire packets and education were updated to include revisions to Vulnerable adult policy and procedures. Quarterly resident interviews will be conducted by social services or her delegate to facilitate the identification of any actual or potential issues. Quarterly QA meeting occurred on 12/16/14. New changes related to the Vulnerable Adult Policy and Procedure were reviewed with the medical director. The Director of Social Services will be responsible for monitoring that all allegations of abuse/neglect or misappropriation are reported and investigated according to facility policy. The Administrator will be responsible for facility compliance. Corrective action for this tag has been completed on 12/18/14.	

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F 224	Continued From page 5 incident." There was no further investigation of the mistreatment to R58, and it was not reported to the state agency. During interview on 11/19/14, 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 incident, and it was not reported to the administrator or state agency because they did not believe there was any abuse that took place and R58 had no ongoing effects from the incident. During interview on 11/19/14, at 2:36 p.m. DON stated when she spoke to NA-D about the incident with R58, NA-D knew how she acted was wrong, and NA-D stated it would not happen again. DON stated NA-D did not receive re-education or corrective action, NA-D was not being monitored to observe her interaction with other residents, there was no further investigation of the incident, and it was not reported to the state agency. DON did not feel this was abuse or mistreatment because R58 was not harmed, and NA-D knew her actions were not acceptable and apologized. R44's annual MDS dated 10/2/14, indicated the resident had diagnoses including Alzheimer's disease, had moderately impaired cognition, and required assistance of one staff with ADL's, and set up assistance with meals. The facility provided a untitled document which was kept in the DON's office regarding an incident involving R44 and NA-D. The document indicated on 11/3/14, NA-D brought R44 to the dining room in his wheelchair and the dining room was not open for breakfast yet. The untitled	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 224	Continued From page 6	F 224		

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 sitting in the hallway in his wheelchair and walked away, and RN-C assisted R44 to get a snack. The untitled 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 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 had 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

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F 224	Continued From page 7	F 224		

On the same untitled document dated 11/3/14, written by RN-C regarding concerns with NA-D and resident mistreatment, indicated NA-D, "What I felt as demeaning to a resident at noon meal, stating rudely that a resident could feed herself, even though this resident does need more assistance to feed herself." There was no follow up with NA-D regarding RN-C concerns of being rude to the resident. During multiple interviews with staff, no one was able to recall who the resident was NA-D had been rude to.

R47's Admission Record dated 11/11/14, included diagnoses of Alzheimer's disease and urinary incontinence. R47's quarterly MDS dated 8/18/14, identified R47 had severe cognitive impairment, was incontinent of bowel and bladder, required extensive assistance of two staff for bed mobility, and was totally dependent on staff for toileting and personal hygiene. During interview on 11/18/14, at 11:19 a.m. family member (FM)-A stated while visiting R47 about five months ago, she stepped out of R47's room into the hallway while two nursing assistants provided personal cares for R47. FM-A heard R47 moaning, and went into R47's room to check on her. FM-A stated she pulled back the privacy curtain, and witnessed an unidentified NA holding R47 on her side, and the NA was leaning on R47 with her elbow, which FM-A felt was causing R47, "Pain." FM-A stated this made her upset, and she reported the incident to 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.

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,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET** **OSAKIS, MN 56360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 8	F 224		

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 another 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 did not feel that they were being rough...It was a one-time thing...There wasn't a lot to it...It 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. This incident was not reportable." SS-A stated she did not report the incident to the administrator, and did not know if it was in their policy that she needed to report the incident to the administrator if it was not considered abuse. SS-A could not recall who the employees were accused of being rough with R47, and stated nothing would be in the employees personal file because it was not determined there was any mistreatment to R47.

During interview on 11/19/14, at 9:00 a.m. DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224		F 224		

Continued From page 9

stated when a complaint is received, the facility should review the incident, "To see if it's reportable...whoever receives the concern follows up with the family...You don't want to over report...If 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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F 224	Continued From page 10	F 224		

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, they had overheard R12 ask NA-J for assistance to use the restroom. NA-J stated to R12, "I told you that when I was done, I would help you. Now be quiet!" The visitor stated she had not told anyone at the facility about this, but stated this had made her uncomfortable as she felt the staff were very rude.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

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F 224	Continued From page 11	F 224		

During interview on 11/21/14, at 10:07 a.m. DON stated the reported incident/ grievance of staff mistreatment involving R12, which was documented on the grievance form dated 11/12/14, had not been reported to the administrator or the SA. DON had no investigation of the incident, and could not verify if any staff were interviewed or re-educated regarding toileting R12.

During interview on 11/18/14, at 11:45 p.m. RN-B stated if the facility had an accusation of staff mistreatment, it would depend on the severity of allegation to determine the investigation, if it required reporting, and if it would be documented. RN-B stated the facility had incident reports, which were mainly used for falls or bruises/ skin tears, grievance forms, which could be filled out for family complaints, and also had forms called Problem/ Resolution forms, which could be used if there were any concerns involving staff. RN-B stated she had not been involved in making any reports to the state agency in the last 7 months, and was not aware accusations staff mistreatment to residents. When RN-B was asked specifically about the incidents involving R52, R58, R12, R47 and R44, RN-B stated she was aware of those incidents, but there was no injury and those were considered more, "Misunderstandings" then actual mistreatment. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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F 224	Continued From page 12 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 facility determined the staff member had "done something to the resident," they would be suspended. 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 investigation of alleged mistreatment by, "Watching to see if there is any changes in behavior..." The DON stated there were no residents in the past 8 months they had needed to monitor for behavior changes related to allegations of staff maltreatment. The DON stated the facility did not feel everything related to allegations of staff mistreatment needed to be documented, and some things could be determined just by checking with a staff member on the incident. DON acknowledged there was	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 224	Continued From page 13 no current system to ensure all allegations were being reported and investigated, nor was there a system in place to track and trend staff involved in resident mistreatment allegations to determine if any staff had a pattern. DON stated staff were not trained to use a certain form to document concerns of resident mistreatment, and the facility had multiple forms including incident reports, grievance forms, and problem/ resolution forms. DON stated some of these forms were kept in a binder in the social workers office, some were in employee files, and some were in a file cabinet in her office. The DON verified the facility had no system to track resident mistreatment. During follow up interview on 11/19/14, at 12:10 a.m. administrator stated he felt like he was involved in the investigation process at the facility. The administrator stated he would expect if there was a complaint of resident mistreatment, the supervisor would listen to the complaint, evaluate it, investigate to the extent warranted immediately, and report to him, "Accordingly." The administrator stated he communicated with the DON about resident 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, "Result in injury." The administrator also stated he was aware residents have felt that staffs communication with them have been, "Less then desired by the resident." The administrator stated staff are aware the need to report to the administrator immediately any allegations of resident mistreatment. He stated, "If it gets to me, if it rises to the level of mistreatment, we	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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F 224	Continued From page 14	F 224		

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 faciltiy 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:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ____ B. WING ____	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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F 224 Continued From page 15 F 224

All staff were trained on the facility abuse prevention policy, which included specific instruction to staff on recognizing abuse and neglect.

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. 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.

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 maltreatment 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	**11/24/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 224	Continued From page 16 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.	F 224		
F 225 SS=L	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		12/18/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 225	Continued From page 17 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to 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 currently residing in the facility. The IJ began on 11/19/14, at 4:19 p.m., when the facility failed to report to the administrator and state agency, investigate, and implement interventions to ensure residents were protected from staff mistreatment to ensure residents were free from staff abuse. The administrator and director of nursing (DON) were notified of the immediate jeopardy (IJ) for all 36 residents in the facility on 11/19/14, at 4:19 p.m. The IJ was removed on 11/24/14, at 1:07 p.m. but noncompliance remained at a widespread scope and severity level, with potential for actual harm.	F 225	F225 Vulnerable adult reports were filed to the state agency on residents #47 and #12 on 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 filed 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 further training on resident transfers and one employee required additional dementia education. The two employees that received further education were allowed to return to work after the education had been completed. All above residents affected had care plans reviewed. No adjustments were required. Mood/behavior focus charting was initiated and completed on all residents #52, 58, 44, 47 and 12 to monitor for any changes in psychosocial wellbeing. No concerns or effects from the filed reports were noted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

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COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 225	Continued From page 18	F 225		

Findings include:

R52's Face Sheet dated 11/20/14, identified diagnoses including hip joint replacement, scoliosis, and pain in the pelvic region and thigh.

R52's quarterly Minimum Data Set (MDS) dated 10/23/14, identified R52 had no cognitive impairment and required extensive weight bearing assistance from two staff for transfers.

During interview on 11/17/14, at 3:34 p.m. R52 stated a few weeks ago, a male nursing assistant (NA) grabbed her on the arm during a transfer from the wheelchair to the bed, and was so rough she hit her hip on the nightstand table. R52 stated she, "Hollered and screamed from the pain," because the transfer was so rough. R52 stated she reported the incident to the registered nurse (RN) case manager, but no one from the facility had spoke to her about the incident.

During another interview on 11/8/14, at 2:53 p.m. R52 again shared her concerns of rough treatment from a staff member during a transfer, and stated she thought the NA was too rough when he assisted her and didn't understand what it was like to be in pain. R52 stated the NA had not provided cares to her since this incident, but she would, "Shy away," from that NA if he were to provide cares to her again due to the pain he caused during the last time he assisted her to transfer.

During interview on 11/18/14, at 3:35 p.m. DON stated she was aware of R52's allegation of a male NA transferring her roughly, and she had spoken with both R52 and the NA about the

Interviews conducted with all nursing staff on 11/19/14 and interviews conducted with all residents in the facility on 11/20/14 to identify other potential cases of resident neglect or mistreatment. During resident interviews, one incident was reported. Incident was immediately reported to state agency. The incident was then investigated per Vulnerable Adult Policy and procedures. Staff member involved was suspended and received additional training on transfers prior to her return to work schedule. Safety Risk assessments were completed on all residents and care plan changes were adjusted.

Zero Tolerance statement initiated by facility administrator. Vulnerable Adult Policy and Procedure was reviewed and revised to include the protection of residents during an alleged act of abuse/neglect. Changes include immediate removal and/or suspension of alleged perpetrator. All licensed staff received training and direction on how to submit an alleged report of abuse to the state agency. An in-service training by a trained consultant was conducted for staff on Vulnerable Adult and Abuse. This education included reviewing the hard copy of the updated Vulnerable Adult Abuse and Prevention Plan, an in-depth discussion on different types of abuse including examples of physical, verbal, and emotional abuse. The staff were also educated on the new disciplinary procedures during reports of alleged abuse. The new Abuse Protocol folders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 225	Continued From page 19 incident. The DON confirmed no report had been made to the SA or administrator regarding the allegation, and there was no documented investigation determining what had happened. During interview on 11/18/14, at 6:29 p.m. social service (SS)-A and the DON were interviewed regarding R52's complaint of rough treatment by the NA. SS-A stated R52's family had called her and reported R52 was upset about rough treatment by staff during a transfer. SS-A stated she had talked to the NA and charge nurse about the incident, however, SS-A stated she had not documented the investigation regarding the findings of the interviews, and she did not report this to the state agency or administrator. SS-A and DON stated they had spoken with R52 about the incident, and the resident did not experience any injury, so they didn't believe the allegation met the definition of potential abuse, neglect, or mistreatment, and determined no report needed to be made to the state agency. SS-A and DON stated there was no documentation regarding any investigation or interviews, and the NA who was accused of rough treatment of R52 had no further training or monitoring to ensure further resident mistreatment did not occur. During interview on 11/18/14, at 3:27 p.m. RN-B stated she was aware R52 had concerns about a month ago regarding being transferred roughly by a NA. RN-B stated interviews had been completed with the NA accused of transferring R52 roughly, as well as with R52, but she had not documented any of the investigation, nor had she reported R52's accusation of rough treatment to the administrator or state agency. RN-B did not feel this met the definition of resident mistreatment that needed to be reported to the	F 225	were also reviewed and the contents of them were discussed at the inservice. The director of nursing conducted 2 staff meetings to review Vulnerable Adult policy and procedures. Policy and Procedures of Morning Standup, Weekly IDT, and Quality Assurance were reviewed and revised to include added communication and review of incidents and Vulnerable Adult trends. Grievances and or incidents will be reviewed on a daily basis during the Morning Standup Meeting and weekly with the IDT team. All unresolved grievances will be reviewed quarterly with the QA team for further review and direction for resolution. An incident log was developed and put into place by the Director of Nursing. All incidents will be reviewed during Morning Standup and then the incident will be placed on the log record. The log will be reviewed weekly during IDT and quarterly with QA to assure that all incidents are fully investigated and complete. A new grievance form was developed and put onto place. Staff were educated by the director of nursing on the location and proper use of the new facility grievance forms. Staff education of Vulnerable Adult Policy and Procedure will continue through QAPI. During resident council on 12/18/14, a review of Vulnerable Adult Policy and Procedure and grievance procedure took place. All IDT weekly log minutes will be reviewed quarterly with the QA team to review incidents and potential	

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	245465	A. BUILDING ______ B. WING ______	11/24/2014

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F 225	Continued From page 20 administrator or state agency because R52 did not experience any injury, and RN-B 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 to the state agency if it rose to the level of mistreatment, for example, if 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 immediately after it had happened, however, he stated he knew the NA accused of the rough transfer with R52, and he did not believe the NA would intentionally mistreat a resident. R58's quarterly MDS dated 10/2/14, indicated R58 had severely impaired cognition, and required assistance with all ADL's, including eating. Review of a facility Problem Resolution form dated 8/7/14, indicated R58 was eating in the dining room and NA-D was overheard telling R58, "You have to eat, there is nothing in your mouth so there is no reason why you won't eat!" NA-D 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 8/8/14, by the RN case manager. [NA-D] stopped in DON office on 8/11/14, to apologize for the incident." There was no further investigation of	F 225	trends of abuse. Upon this review system revisions and/or staff education will be implemented indicated via proscribed written action plan. New employee hire packets and education were updated to include revisions to Vulnerable adult policy and procedures. Quarterly resident interviews will be conducted by social services or her delegate to facilitate the identification of any actual or potential issues. Quarterly QA meeting occurred on 12/16/14. New changes related to the Vulnerable Adult Policy and Procedure were reviewed with the medical director. The Director of Social Services will be responsible for monitoring that all allegations of abuse/neglect or misappropriation are reported and investigated according to facility policy. The Administrator will be responsible for facility compliance. Corrective action for this tag has been completed on 12/18/14.	

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F 225	Continued From page 21	F 225		

the mistreatment to R58, and it was not reported to the state agency or administrator.
During interview on 11/19/14, 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 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 had no ongoing effects from the incident.
During interview on 11/19/14, at 2:36 p.m. DON stated when she spoke to NA-D about the incident with R58, NA-D knew how she acted was wrong, and NA-D stated it would not happen again. DON stated NA-D did not receive re-education or corrective action, NA-D was not being monitored to observe her interaction with other residents, there was no further investigation of the incident, and it was not reported to the state agency or administrator. DON did not feel this was abuse or mistreatment because R58 was not harmed, and NA-D knew her actions were not acceptable and apologized.
R44's annual MDS dated 10/2/14, indicated the resident had diagnoses including Alzheimer's disease, had moderately impaired cognition, and required assistance of one staff with activities of daily living (ADL's), and set up assistance with meals.
The facility provided an untitled document, which was kept in the DON's office, indicating on 11/3/14, NA-D brought R44 to the dining room in his wheelchair and the dining room was not opened for breakfast yet. The untitled document indicated NA-D very loudly stated the dining room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

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F 225	Continued From page 22 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 sitting in the hallway in his wheelchair and walked away, and RN-C assisted R44 to get a snack. The untitled 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 she reported it to the DON. On 11-3-14, NA-D, RN-C, and 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 or other residents. During interview on 11/19/14, at 2:36 p.m. the DON stated NA-D had 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 or administrator. 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,	F 225		

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	245465	A. BUILDING ______ B. WING ______	**11/24/2014**

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COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 225	Continued From page 23 written by RN-C regarding concerns with NA-D and resident mistreatment, indicated NA-D was, "What I felt as demeaning to a resident at noon meal, stating rudely that a resident could feed herself, even though this resident does need more assistance to feed herself." There was no follow up with NA-D regarding RN-C concerns of being rude to the resident or possible neglect of providing necessary care. During multiple interviews with staff, no one was able to recall who the resident was NA-D had been rude to. The incident was not reported to the state agency or administrator, and there was no further investigation. R47's Admission Record dated 11/11/14, included diagnoses of Alzheimer's disease and urinary incontinence. R47's quarterly MDS dated 8/18/14, identified R47 had severe cognitive impairment, was incontinent of bowel and bladder, required extensive assistance of two staff for bed mobility, and was totally dependent on staff for toileting and personal hygiene. During interview on 11/18/14, at 11:19 a.m. FM-A stated while visiting R47 about five months ago, she stepped out of R47's room into the hallway while two nursing assistants provided personal cares for R47. FM-A heard R47 moaning, and went into R47's room to check on her. FM-A stated she pulled back the privacy curtain, and witnessed an unidentified NA holding R47 onto 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.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET** **OSAKIS, MN 56360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 24 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 rough...It was a one-time thing...There wasn't a lot to it...It 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. This incident was not reportable." SS-A stated she did not report the incident to the administrator, and did not know if it was in their policy that she needed to report the incident to the administrator if it was not considered abuse. SS-A could not recall who the employees were accused of being rough with R47, and stated nothing would be in the employees personal file	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 25	F 225		

because it was not determined there was any mistreatment to R47. This was not reported to the state agency or administrator.

During interview on 11/19/14, at 9:00 a.m. DON stated when a complaint is received, the facility should review the incident, "To see if it's reportable...whoever receives the concern follows up with the family...You don't want to over report...If 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

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F 225	Continued From page 26	F 225		

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 without toileting R12. 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, they had overheard R12 ask NA-J for assistance to use the restroom. NA-J stated to R12, "I told

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	**11/24/2014**

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COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 225	Continued From page 27	F 225		

you that when I was done, I would help you. Now be quiet!" The visitor stated she had not told anyone at the facility about this, but stated this had made her uncomfortable as she felt the staff were very rude.

During interview on 11/21/14, at 10:07 a.m. DON stated the reported incident/ grievance of staff mistreatment involving R12, which was documented on the grievance form dated 11/12/14, had not been reported to the administrator or the SA. DON had no investigation of the incident, and could not verify if any staff were interviewed or re-educated regarding toileting R12 and being rude to the resident.

During interview on 11/18/14, at 11:45 p.m. RN-B stated if the facility had a accusation of staff mistreatment, it would depend on the severity of allegation to determine the investigation, if it required reporting, and if it would be documented. RN-B stated the facility had incident reports, which were mainly used for falls or bruises/ skin tears, grievance forms, which could be filled out for family complaints, and also had forms called Problem/ Resolution forms, which could be used if there were any concerns involving staff. RN-B stated she had not been involved in making any reports to the state agency or administrator in the last 7 months, and was not aware accusations staff mistreatment to residents. When RN-B was asked specifically about the incidents involving R52, R58, R12, R47 and R44, RN-B stated she was aware of those incidents, but there was no 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	**11/24/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 225	Continued From page 28 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 investigation of alleged mistreatment by, "Watching to see if there is any changes in behavior..." The DON stated there were no residents in the past 8 months they needed to	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 29 monitor for behavior changes related to allegations of staff mistreatment. The DON stated the facility did not feel everything related to allegations of staff mistreatment needed to be documented, and some things could be determined just by checking with a staff member on the incident. DON acknowledged there was no current system to ensure all allegations were being reported to the state agency and administrator, and thoroughly investigated, nor was there a system in place to track and trend staff involved in resident mistreatment allegations to determine if any staff had a pattern. DON stated staff were not trained to use a specific form to document concerns of resident mistreatment, and the facility had multiple forms including incident reports, grievance forms, and problem/ resolution forms. DON stated some of these forms were kept in a binder in the social workers office, some were in employee files, and some were in a file cabinet in her office. The DON verified the facility had no system to track resident mistreatment or to ensure all allegations of resident mistreatment were reported to the administrator and SA. During follow up interview on 11/19/14, at 12:10 a.m. administrator stated he felt like he was involved in the investigation process at the facility. The administrator stated he would expect if there was a complaint of resident mistreatment, the supervisor would listen to the complaint, evaluate it, investigate to the extent warranted immediately, and report to him, "Accordingly." The administrator stated he communicated with the DON about resident 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	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 225	Continued From page 30 believed the facility understood the process of investigation, reporting, and resident protection, however, not all allegations of mistreatment, "Result in injury." The administrator also stated he was aware residents have felt that staffs communication with them have been, "Less then desired by the resident." The administrator stated staff are aware the need to report to the administrator immediately any allegations of resident mistreatment. He stated, "If it gets to me, if it rises to the level of mistreatment, we 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 had a very small facility, so management feels like they know their 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	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	**11/24/2014**

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F 225	Continued From page 31	F 225		

R12. DON verified the investigations were not complete and lacked the above information. On 11/21/14, the faciltiy 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

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F 225	Continued From page 32 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.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 33	F 225		
F 226 SS=F	. 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to 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 when an investigation was taking place of an allegation of resident mistreatment. This had the potential to affect all 36 residents currently residing in the facility. Findings include: The facility policy titled Vulnerable Adult Policy and Procedure/Prevention Plan dated 4/17/14, indicated the following: "Incident reports are required for non-therapeutic physical contact between staff/ resident and resident/ resident...	F 226	F226 Vulnerable adult reports were filed to the state agency on residents #47 and #12 on 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 filed 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 further training on resident transfers and one employee required additional dementia education. The two employees that received further education were allowed to return to work after the education had been completed. All above residents affected had care plans reviewed. No	12/18/14

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F 226	Continued From page 34 The DON/ case manager will look for possible... patterns, occurrences, or trends that may indicate need for reporting. After investigation, the DON/ case manager will make a reporting decision... The administrator, department supervisor, DON and other staff as needed are involved in the investigation. Interviews with resident, family, and staff are solicited to gain the best understanding of the event. When an investigation reveals abuse/ neglect has occurred, the staff member must be separated from the resident. The nurse in charge will decide if the staff member can be reassigned to another area or must leave the building until further notice... All staff need to report suspected maltreatment of a vulnerable adult (VA) to the supervising nurse on duty or social services (SS). In addition, the facility Administrator must be notified of every report immediately. Staff should complete the form, Report of Suspected abuse/ Neglect of a VA... Initial incident report must be given to [SA] immediately after knowledge of the incident is received where there is reason to believe a resident is or has been maltreated or a resident has sustained a physical injury which is not reasonable explained... The administrator (when on duty) or, in place of the administrator, the DON, SS, or supervising nurse responsible for the resident will be the person submitting [the report to the SA]..." Findings include: R52's Face Sheet dated 11/20/14, identified diagnoses including hip joint replacement, scoliosis, and pain in the pelvic region and thigh. R52's quarterly Minimum Data Set (MDS) dated 10/23/14, identified R52 had no cognitive	F 226	adjustments were required. Mood/behavior focus charting was initiated and completed on all residents #52, 58, 44, 47 and 12 to monitor for any changes in psychosocial wellbeing. No concerns or effects from the filed reports were noted. Interviews conducted with all nursing staff on 11/19/14 and interviews conducted with all residents in the facility on 11/20/14 to identify other potential cases of resident neglect or mistreatment. During resident interviews, one incident was reported. Incident was immediately reported to state agency. The incident was then investigated per Vulnerable Adult Policy and procedures. Staff member involved was suspended and received additional training on transfers prior to her return to work schedule. Safety Risk assessments were completed on all residents and care plan changes were adjusted. Zero Tolerance statement initiated by facility administrator. Vulnerable Adult Policy and Procedure was reviewed and revised to include the protection of residents during an alleged act of abuse/neglect. Changes include immediate removal and/or suspension of alleged perpetrator. All licensed staff received training and direction on how to submit an alleged report of abuse to the state agency. An in-service training by a trained consultant was conducted for staff on Vulnerable Adult and Abuse. This education included reviewing the hard copy of the updated Vulnerable Adult	

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F 226	Continued From page 35	F 226		

impairment and required extensive weight bearing assistance from two staff for transfers.

During interview on 11/17/14, at 3:34 p.m. R52 stated a few weeks ago, a male nursing assistant (NA) grabbed her on the arm during a transfer from the wheelchair to the bed, and was so rough she hit her hip on the nightstand table. R52 stated she, "Hollered and screamed from the pain," because the transfer was so rough. R52 stated she reported the incident to the registered nurse (RN) case manager, but no one from the facility had spoke to her about the incident.

During another interview on 11/8/14, at 2:53 p.m. R52 again shared her concerns of rough treatment from a staff member during a transfer, and stated she thought the NA was too rough when he assisted her and didn't understand what it was like to be in pain. R52 stated the NA had not provided cares to her since this incident, but she would, "Shy away," from that NA if he were to provide cares to her again due to the pain he caused during the last time he assisted her to transfer.

During interview on 11/18/14, at 3:35 p.m. DON stated she was aware of R52's allegation of a male NA transferring her roughly, and she had spoken with both R52 and the NA about the incident. The DON confirmed no report had been made to the SA regarding the allegation, and there was no documented investigation determining what had happened according to the facility policy.

During interview on 11/18/14, at 6:29 p.m. social service (SS)-A and the DON were interviewed regarding R52's complaint of rough treatment by

Abuse and Prevention Plan, an in-depth discussion on different types of abuse including examples of physical, verbal, and emotional abuse. The staff were also educated on the new disciplinary procedures during reports of alleged abuse. The new Abuse Protocol folders were also reviewed and the contents of them were discussed at the inservice. The director of nursing conducted 2 staff meetings to review Vulnerable Adult policy and procedures. Policy and Procedures of Morning Standup, Weekly IDT, and Quality Assurance were reviewed and revised to include added communication and review of incidents and Vulnerable Adult trends. Grievances and or incidents will be reviewed on a daily basis during the Morning Standup Meeting and weekly with the IDT team. All unresolved grievances will be reviewed quarterly with the QA team for further review and direction for resolution. An incident log was developed and put into place by the Director of Nursing. All incidents will be reviewed during Morning Standup and then the incident will be placed on the log record. The log will be reviewed weekly during IDT and quarterly with QA to assure that all incidents are fully investigated and complete. A new grievance form was developed and put onto place. Staff were educated by the director of nursing on the location and proper use of the new facility grievance forms.

Staff education of Vulnerable Adult Policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 226	Continued From page 36 the NA. SS-A stated R52's family had called her and reported R52 was upset about rough treatment by staff during a transfer. SS-A stated she had talked to the NA and charge nurse about the incident, however, SS-A stated she had not documented the investigation regarding the findings of the interviews, and she did not report this to the state agency or administrator. SS-A and DON stated they had spoken with R52 about the incident, and the resident did not experience any injury, so they didn't believe the allegation met the definition of potential abuse, neglect, or mistreatment, and determined no report needed to be made to the state agency. SS-A and DON stated there was no documentation regarding any investigation or interviews, and the NA who was accused of rough treatment of R52 had no further training or monitoring to ensure further resident mistreatment did not occur. DON verified the facility policy directed any allegations of abuse should be reported immediately to the administrator and state agency, and this was not completed for R52. During interview on 11/18/14, at 3:27 p.m. RN-B stated she was aware R52 had concerns about a month ago regarding being transferred roughly by a NA. RN-B stated interviews had been completed with the NA accused of transferring R52 roughly, as well as with R52, but she had not documented any of the investigation, nor had she reported R52's accusation of rough treatment to the administrator or state agency per facility policy. 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 maltreatment because R52 did not experience any injury and felt it was more of a misunderstanding between the R52 and the	F 226	and Procedure will continue through QAPI. During resident council on 12/18/14, a review of Vulnerable Adult Policy and Procedure and grievance procedure took place. All IDT weekly log minutes will be reviewed quarterly with the QA team to review incidents and potential trends of abuse. Upon this review system revisions and/or staff education will be implemented indicated via proscribed written action plan. New employee hire packets and education were updated to include revisions to Vulnerable adult policy and procedures. Quarterly resident interviews will be conducted by social services or her delegate to facilitate the identification of any actual or potential issues. Quarterly QA meeting occurred on 12/16/14. New changes related to the Vulnerable Adult Policy and Procedure were reviewed with the medical director. The Director of Social Services will be responsible for monitoring that all allegations of abuse/neglect or misappropriation are reported and investigated according to facility policy. The Administrator will be responsible for facility compliance. Corrective action for this tag has been completed on 12/18/14.	

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F 226	Continued From page 37	F 226		

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, if 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 intentionally mistreat a resident. The administrator verified the facility policy instructed staff to report any alleged resident mistreatment to the state agency, and then investigate, however, this was not completed.
R58's quarterly MDS dated 10/2/14, indicated R58 had severely impaired cognition, and required assistance with all ADL's, including eating.
Review of a facility Problem Resolution form dated 8/7/14, indicated R58 was eating in the dining room and NA-D was overheard telling R58, "You have to eat, there is nothing in your mouth so there is no reason why you won't eat!" NA-D 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 8/8/14, by the RN case manager. [NA-D] stopped in DON office on 8/11/14, to apologize for the incident." There was no further investigation of the mistreatment to R58, and it was not reported

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F 226	Continued From page 38 to the state agency according to the facility policy. During interview on 11/19/14, 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 incident, and it was not reported to the administrator or state agency because they did not believe there was any abuse that took place and R58 had no ongoing effects from the incident. During interview on 11/19/14, at 2:36 p.m. DON stated when she spoke to NA-D about the incident with R58, NA-D knew how she acted was wrong, and NA-D stated it would not happen again. DON stated NA-D did not receive re-education or corrective action, NA-D was not being monitored to observe her interaction with other residents, there was no further investigation of the incident, and it was not reported to the state agency according to the facility policy. DON did not feel this was abuse or mistreatment because R58 was not harmed, and NA-D knew her actions were not acceptable and apologized. R44's annual MDS dated 10/2/14, indicated the resident had diagnoses including Alzheimer's disease, had moderately impaired cognition, and required assistance of one staff with activities of daily living (ADL's), and set up assistance with meals. The facility provided a untitled document which was kept in the DON's office regarding an incident involving R44 and NA-D. The document indicated on 11/3/14, NA-D brought R44 to the dining room in his wheelchair and the dining room was not opened for breakfast yet. The untitled document indicated NA-D very loudly stated the	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

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F 226	Continued From page 39	F 226		

Continued From page 39

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 sitting in the hallway in his wheelchair and walked away, and RN-C assisted R44 to get a snack. The untitled 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 she reported it to the DON. On 11-3-14, NA-D, RN-C, and 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.

During interview on 11/19/14, at 2:36 p.m. DON stated NA-D had 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 according to the facility policy. 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,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 226	Continued From page 40	F 226		

written by RN-C regarding concerns with NA-D and resident mistreatment, indicated NA-D was, "What I felt as demeaning to a resident at noon meal, stating rudely that a resident could feed herself, even though this resident does need more assistance to feed herself." There was no follow up with NA-D regarding RN-C concerns of being rude to the resident. During multiple interviews with staff, no one was able to recall who the resident was NA-D had been rude to.
R47's Admission Record dated 11/11/14, included diagnoses of Alzheimer's disease and urinary incontinence. R47's quarterly MDS dated 8/18/14, identified R47 had severe cognitive impairment, was incontinent of bowel and bladder, required extensive assistance of two staff for bed mobility, and was totally dependent on staff for toileting and personal hygiene.
During interview on 11/18/14, at 11:19 a.m. FM-A stated while visiting R47 about five months ago, she stepped out of R47's room into the hallway while two nursing assistants provided personal cares for R47. FM-A heard R47 moaning, and went into R47's room to check on her. FM-A stated she pulled back the privacy curtain, and witnessed an unidentified NA holding R47 onto 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 226	Continued From page 41	F 226		

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 another interview on 11/19/14, at 8:52 a.m., SS-A stated she now recalled she had reported the incident with R47 and 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 who were providing R47 cares that day, and, "They did not feel that they were being rough...It was a one-time thing...There wasn't a lot to it...It 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. This incident was not reportable." SS-A stated she did not report the incident to the administrator, and did not know if it was in their policy that she needed to report the incident to the administrator if it was not considered abuse. SS-A could not recall who the employees were accused of being rough with R47, and stated nothing would be in the employees personal file because it was not determined there was any mistreatment to R47. SS-A verified she had not followed up with FM-A regarding the allegation of staff maltreatment, and she did not report the allegation of abuse to the state agency according to the facility policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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F 226	Continued From page 42 During interview on 11/19/14, at 9:00 a.m. DON stated when a complaint is received, the facility should review the incident, "To see if it's reportable...whoever receives the concern follows up with the family...You don't want to over report...If 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, and she did not believe FM-A was followed up with regarding the allegation of abuse to 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. The administrator acknowledged the facility policy directs staff to notify the SA immediately, and then complete an investigation.	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

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F 226	Continued From page 43	F 226		

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,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 226	Continued From page 44	F 226		

they had overheard R12 ask NA-J for assistance to use the restroom. NA-J stated to R12, "I told you that when I was done, I would help you. Now be quiet!" The visitor stated she had not told anyone at the facility about this, but stated this had made her uncomfortable as she felt the staff were very rude.

During interview on 11/21/14, at 10:07 a.m. DON stated the reported incident/ grievance of staff mistreatment involving R12, which was documented on the grievance form dated 11/12/14, had not been reported to the administrator or the SA according to the facility policy. DON had no investigation of the incident, and could not verify if any staff were interviewed or re-educated regarding toileting R12.

During interview on 11/18/14, at 11:45 p.m. RN-B stated if the facility had a accusation of staff mistreatment, it would depend on the severity of allegation to determine the amount of investigation, if it required reporting, and if it would be documented. RN-B stated the facility had incident reports, which were mainly used for falls or bruises/ skin tears, grievance forms, which could be filled out for family complaints, and also had forms called Problem/ Resolution forms, which could be used if there were any concerns involving staff. RN-B stated she had not been involved in making any reports to the state agency in the last 7 months, and was not aware accusations staff mistreatment to residents. When RN-B was asked specifically about the incidents involving R52, R58, R12, R47 and R44, RN-B stated she was aware of those incidents, but there was no injury and those were considered more, "Misunderstandings" then actual mistreatment. RN-B stated if she is made

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	**11/24/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 226	Continued From page 45 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. RN-B stated she was aware the facility policy instructed staff to notify the administrator and SA immediately of any resident abuse, and then investigate. RN-B stated there had been no concerns with abuse, so nothing required notification to the SA or administrator. 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/ allegations of staff mistreatment to residents, 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 immediately. 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	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

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F 226	Continued From page 46	F 226		

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 investigation of alleged mistreatment by, "Watching to see if there is any changes in behavior..." The DON stated there were no residents in the past 8 months they had needed to monitor for behavior changes related to allegations of staff mistreatment. The DON stated the facility did not feel everything related to allegations of staff mistreatment needed to be documented and/ or reported to the SA and administrator, and some things could be determined just by checking with a staff member on the incident. DON acknowledged there was no current system to ensure all allegations were being reported and investigated, nor was there a system in place to track and trend staff involved in resident mistreatment allegations to determine if any staff had a pattern. DON stated staff were not trained to use a certain form to document concerns of resident mistreatment, and the facility had multiple forms including incident reports, grievance forms, and problem/ resolution forms. DON stated some of these forms were kept in a binder in the social workers office, some were in employee files, and some were in a file cabinet in her office. The DON verified the facility had no system to track resident mistreatment, and the facility was not following their abuse policy for reporting and investigating allegations of resident abuse.

During follow up interview on 11/19/14, at 12:10 a.m. administrator stated he felt like he was involved in the investigation process at the facility. The administrator stated her would expect if there was a complaint of resident mistreatment, the supervisor would listen to the complaint, evaluate

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	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 226	Continued From page 47 it, investigate to the extent warranted immediately, and report to him, "Accordingly." The administrator stated he communicated with the DON about resident 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, "Result in injury." The administrator also stated he was aware residents have felt that staffs communication with them have been, "Less then desired by the resident." The administrator stated staff are aware the need to report to the administrator immediately any allegations of resident mistreatment. He stated, "If it gets to me, if it rises to the level of mistreatment, we 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. The administrator verified the facility policy instructed staff to report any allegations of resident mistreatment immediately to the SA and administrator, and then complete an investigation, however, the administrator was unable to verify if staff was following the facility abuse policy.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a	F 241		12/18/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	**11/24/2014**

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COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 241	Continued From page 48 manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 10 of 13 residents who required staff assistance with eating (R1, R3, R10, R14, R19, R21, R25, R40, R46 and R58) were provided dining assistance in a dignified manner. Findings include: R1's quarterly Minimum Data Set (MDS) dated 9/11/14, identified R1 was severely cognitively impaired and required extensive assistance with eating. R3's annual MDS dated 9/18/14, identified R3 was severely cognitively impaired and required extensive assistance with eating. R10's quarterly MDS dated 9/25/14, identified R10 was severely cognitively impaired and required extensive assistance with eating. R14's annual MDS dated 8/21/14, identified R14 was severely cognitively impaired and required extensive assistance with eating. R19's quarterly MDS dated 8/7/14, identified R19 was severely cognitively impaired and required extensive assistance with eating. R21's admission MDS dated 9/20/14, identified R21 was severely cognitively impaired and was totally dependent on staff for eating.	F 241	F241: Facility reviewed R1,3,10,14,19, 21, 25, 40, 46, 58 for appropriate dining and interventions added as appropriate per review of resident care plans. All other residents needed assist in the dining room were assessed to assure that all needed and appropriate interventions were in place. Resident seating arrangements were reviewed, no changes required. Staffing was reviewed and adjusted in accordance with acuity and meal times to ensure appropriate staff was in place to assist residents with all meals. Staff education was completed to ensure that all staff were aware of appropriate diningroom conduct and providing dining room assist to residents in a dignified manner. Reviewed and revised Dignity Policy and Procedure and Dining and Food Service Policy and Procedure. The changes to these policies were reviewed with QA team. Audits will be conducted by the dietary manager or her delegate 8x/wk for one	

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	245465	A. BUILDING ______ B. WING ______	11/24/2014

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COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 241	Continued From page 49 R25's quarterly MDS dated 10/16/14, identified R25 was severely cognitively impaired and required extensive assistance with eating. R40's annual MDS dated 10/9/14, identified R40 was severely cognitively impaired and was totally dependent on staff for eating. R46's annual MDS dated 8/21/14, identified R46 was severely cognitively impaired and required extensive assistance with eating. R58's quarterly MDS dated 10/2/14, identified R58 was severely cognitively impaired and required extensive assistance with eating. During observation of the evening meal on 11/17/14, from 6:04 p.m. to 6:37 p.m., nursing assistant (NA)-A was observed sitting on a round stool which had wheels on. NA-A wheeled around two tables where R25, R46, R40, R14, R58 and R19 sat. NA-A would spend a few minutes feeding one resident, and then would wheel around to another resident either at the same table or another table and feed them for a few minutes, and then roll away to another resident to assist them with eating. NA-A stopped rolling on the stool, stood up, and spoke with R19 twice encouraging the resident to eat. R19 refused to eat. NA-A did not sit down or spend more than a few seconds encouraging R19 to eat. At 6:37 p.m., NA-A started removing residents from the dining room. During the same meal observation from 6:03 p.m. until 6:27 p.m., NA-D was observed alternating between a stool with wheels, and stationary chairs placed around tables while assisting R21,	F 241	quarter to assure that compliance is maintained by staff. The results of these audits will be reviewed weekly during the IDT meeting and then reviewed with the QA team to evaluate the outcome from audits Corrective action for this tag was completed on 12/18/14.	

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	245465	A. BUILDING ______ B. WING ______	11/24/2014

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F 241	Continued From page 50	F 241		

R10, R1 and R3. During the meal NA-D was observed telling R1 she was, "Going to help [R21] now." R1 continued to ask for bites of food and NA-D replied, "I know, we're just going to assist everyone else for a bit. We're not going to forget you." R1 was observed attempting to drink from a straw several different times, but was unable to do so without assistance.

During interview on 11/20/14, at 2:10 p.m. trained medication aid (TMA)-A stated there was usually four staff in the dining room during the evening meal to assist approximately 12 residents who required assistance with eating. TMA-A stated staff usually feed the residents who could eat the fastest first and then move on to the others. TMA-A stated an hour was the typical time it took from the beginning of the meal to the end, when the last person who needed assistance was finished eating.

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 required assistance with eating in the dining room during the evening meal. RN-A stated which the resident who arrived in the dining room first, is who got fed first. RN-A stated she did not think serving all the residents at the same time and then wheeling around every couple of minutes was a dignified dining experience, and felt the residents should not be rushed and mealtime should be home like. RN-A stated should focus on feeding possibly 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 getting cold while waiting.

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COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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F 241	Continued From page 51 During interview on 11/20/14, at 5:22 p.m. NA-G recalled being present in the dining room during the meal on 11/17/14. NA-G did not recall observing NA-A or NA-D wheeling around the dining room, but stated it was not a dignified manner of feeding residents. During interview on 11/21/14, at 1:50 p.m. the administrator stated he was aware staff were using stools with wheels on them and working to feed multiple residents at the same time. The administrator stated it was obviously not ideal. 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.	F 241		
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain comfortable room temperatures for 1 of 3 residents (R45) reviewed for complaints of cold room temperatures. Findings include: R45's quarterly Minimum Data set (MDS) dated 10/16/14, indicated R45 had no cognitive	F 257	F257 Maintenance director ordered and completed installation on a new thermostat in resident #45 s room on 12/3/14. Temperature audit was completed following installation. Resident stated satisfaction and no further complaints of cold room temperature since installation of new thermostat has	12/15/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 257	Continued From page 52 impairment. During interview on 11/17/14, at 6:10 p.m. R45 stated his room was too cold. R45 was wearing a long sleeved shirt and was covered with a blanket. The thermostat in R45's room read 68 degrees. During observation of R45's room on 11/20/14, at 9:00 a.m. the thermometer read 66 degrees. R45 was not in his room at this time. During observation of R45's room on 11/20/14, at 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 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	F 257	occurred with resident #45. Resident interviews completed by maintenance director on 12/4/14. No other concerns reported by residents in facility of room temperature issues. A policy on resident room temperatures was developed on 12/4/14 and modified last on 12/15/14 by the maintenance director. The maintenance director or his delegate will audit all resident rooms weekly which will be ongoing. A room temp log was created and put into use to document these audits on resident room temperatures. Any discrepancies or grievances regarding the temperature of resident rooms will be documented on a grievance report and reviewed with the maintenance director to assure follow up has been completed and that room temperatures remain within the federal requirements of 71-81 degrees F. The corrective action for this tag was completed on 12/15/14.	

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F 257	Continued From page 53 getting in. "	F 257		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to revise the plan of care for 1 of 3 residents (R21) with significant weight loss. Findings include: R21's admission Minimum Data Set (MDS) dated 9/20/14, identified R21 was severely cognitively impaired and was totally dependent on staff for eating.	F 280	F280 R21 was re-evaluated and assessed to assure that appropriate interventions were in place and care planned appropriately. R 21 was admitted to Hospice on 12/8/14. Dietary manager reviewed all other residents in the facility for risk or potential for weight loss. Care plans updated	12/18/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 280

Continued From page 54

R21's care plan dated 11/17/14, 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. The care plan did not identify R21 had sustained any weight loss.

R21's nutritional risk assessment completed 9/23/14, identified R21's weight was 159 pounds, received a regular, pureed texture diet, was unable to make meal/food preferences known, was totally fed by staff, and did not make any attempt to feed himself. .

R21's documented weights included the following:
- 9/17/14 159 pounds
- 10/1/14 156.5 pounds
- 10/8/14 156 pounds
- 10/15/14 151.5 pounds
- 10/22/14 149.5 pounds which was flagged as a 6% decrease from 159 pounds less than a month prior
- 10/29/14 148.5 pounds which was a loss of 10.5 pounds since admission
- 11/12/14 148 pounds
- 11/19/14 146 pounds which flagged as 8.2% weight loss from 159 or 13 pounds three months earlier

During interview on 11/20/14, at 9:14 a.m. dietary manager (DM)-A stated the computer system would trigger a notification for her when a resident's weight dropped 5% or greater. DM-A stated R21 had first triggered for weight loss on 10/22/14, with a loss of 6%. DM-A stated she would complete the nutritional part of a resident's care plan, and confirmed as of 11/17/14, R21's care plan had not been updated to reflect

F 280

accordingly to results of audits.

Policy and procedure on Resident Weight Loss was reviewed and revised by the dietary manager. Certified dietary manager will print off weight summary report weekly and review with registered dietician monthly or as needed with significant unplanned resident weight loss, weekly to RN case managers and DON, weekly IDT meetings and quarterly during QA meetings.

Dietary manager will conduct ongoing weekly weight audits on all residents in the facility to track and address residents with weight loss. The results of these audits will be shared with the RN Case managers, members of IDT and QA team to assure all interventions are in place and appropriate. The DON or designee will review weekly audit reports to assure that all weight loss is care planned and appropriate interventions have been implemented. The results of these audits will be brought forth to the quarterly QA meeting to assure that all interventions were placed and policies were followed.

The corrective action for this tag was completed on 12/18/14.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 55 nutritional status related to the weight loss. 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 review the care plan for pertinent information. A facility policy titled Care Conferences and Careplan Process last updated on 1/20/10, indicated information for the care plan may come from all disciplines and will be written and updated for each department by staff members trained to write care plans. Care plans would be reviewed monthly, quarterly, and as needed.	F 280		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide proper wheelchair positioning for 4 of 4 residents (R1, R10, R50, and R47) reviewed for wheelchair positioning.	F 309	F309 R1, 10,47 and 50 were screened by OT and orders obtained for assessment of wheelchair positioning. All other residents in facility that utilize Broda chairs were screened and orders	12/19/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309 — Continued From page 56

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.

R1's care plan dated 11/21/14, identified R1 used a full BRODA (a type of reclining wheelchair) for locomotion and seating.

During observation on 11/17/14, at 6:34 p.m. R1 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.

During observation on 11/18/2014, at 2:35 p.m. R1 was again observed with her feet dangling down on her wheelchair footrest with no foot support, and wheelchair cushion remained behind her feet. R1 was continuously observed until 3:27 p.m. when nursing assistant (NA)-A laid R1 down in bed. R1's feet remained dangling above the foot rest with no support for almost an hour.

During interview on 11/18/14, at 3:17 p.m. nursing assistant (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. She further stated R1's positioning in the chair was "not very good" if the pillows were not in place.

During further interview on 11/18/14, at 3:28 p.m.

F 309 (Provider's plan of correction):

obtained if positioning concerns were noted.
Policy and Procedure for Resident Therapy Screens was developed and implemented to address seating and positioning. Licensed nursing staff and contracted therapy staff were educated on new policy. Policy was reviewed during Quarterly QA meeting.
Audits will be completed by the DON or her delegate to assure that all new admissions, residents with significant changes, and or residents that required review of positioning, have occurred and the results of those audits will be shared with weekly IDT and quarterly QA team to evaluate that policies have been followed.
The corrective action for this tag will be completed on 12/19/14.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

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F 309	Continued From page 57	F 309		

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. the occupational therapist (OT) stated she disliked the BRODA chairs for residents. OT stated R1 had been put in her current chair due to gaining weight and needing a larger chair, and the facility lacked another type of reclining wheelchair which would fit R1. OT was not involved in determining if R1's current wheelchair was appropriate for the resident. OT stated she reported concerns of lack of wheelchair equipment for all residents to management as recently as the previous week, however, the facility's funding for wheelchair equipment was limited.

R10's quarterly MDS dated 9/25/14, indicated the 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 309	Continued From page 58	F 309		

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 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.

During observation on 11/19/14, at 7:51 a.m. R50

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ____ B. WING ____	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 59	F 309		

was observed seated in the BRODA chair in the dining room. The BRODA chair was in the upright position, and R50's feet were dangling above the floor and did not touch the floor.

During interview on 11/20/14, at 2:08 p.m. the occupational therapist (OT) stated R50 had been put in the BRODA chair due to a diagnoses of kyphosis (a condition that causes excessive curvature of the spine). OT stated R50's wheelchair positioning was, "Not very good," and stated the residents feet should touch the floor so he could propel himself.

R47's quarterly MDS dated 8/7/14, indicated the resident had severe cognitive impairment and required extensive staff assistance to and from destinations with a wheelchair.

R47's care plan dated 11/21/14, indicated R47 used a wheelchair for all mobility.

R47's OT therapy notes dated 11/12/14, indicated R47 had weakness and poor positioning in her tilt in space wheelchair.

R7's nursing progress notes identified the following:
-11/6/14, at 10:42 a.m. - Recent falls, trend of leaning forward in wheelchair
-11/13/14, at 4:04 p.m. - Resident slouched in wheelchair
-11/14/14, at 5:37 a.m. - Resident slouched in wheelchair
-11/15/14, at 5:49 a.m.- Resident slouched in wheelchair
-11/16/14, at 5:59 a.m. - Resident with hunched position in wheelchair, slumped posture

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 60	F 309		

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 and the facility did not have another suitable wheelchair for 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 R47 with an appropriate fitting wheelchair.

During observation on 11/21/2014, at 9:30 a.m. R47 was observed in a slouched position, sliding down in her wheelchair while trying to propel herself down the hallway.

During interview on 11/21/14, at 1:53 p.m. the administrator stated the facility discussed equipment needs, however, he was not aware of any concerns related to lack of appropriate fitting wheelchair equipment for residents.

A policy regarding wheelchair positioning was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 61 requested but not provided.	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This 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. During observation of the evening meal on 11/17/14, at 6:03 p.m. R25 had a plate of food in front of her, and a variety of liquids. No staff were present at the table to assist R25 to eat, and the plate of food was just set in front of her. At 6:21 p.m., 18 minutes later, nursing assistant (NA)-A sat down and assisted R25 to eat. At 6:29 p.m. NA-A got up from the stool, began writing on a piece of paper, and walked away from R25. At 6:52 p.m., 23 minutes later, TMA-A sat down and assisted R25 to finish her meal, and at 6:59 p.m. R25 was taken out of the dining room. R25's meal lasted 56 minutes, and ate approximately 25% of the meal.	F 312	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 the dining room were assessed to assure that all needed and appropriate interventions were in place. Resident seating arrangements were reviewed, no changes required. Staffing was reviewed and adjusted in accordance with acuity and meal times to ensure appropriate staff was in place to assist residents with all meals. Staff education was completed to ensure that all staff were aware of appropriate diningroom conduct and providing dining room assist to residents in a dignified manner. Reviewed and revised Dignity Policy and Procedure and Dining and Food Service	12/18/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 312	Continued From page 62 R40's annual MDS dated 10/9/14, identified R40 was severely cognitively impaired and totally dependent on staff with eating. During observation of the evening meal on 11/17/14, at 6:04 p.m., NA-A got up from feeding R40. At 6:14 p.m., NA-A returned and continued to feed R40 for four minutes, and then left R40 again to feed another resident. Seven minutes later, at 6:25 p.m., TMA-A sat down and fed R40 until 6:48 p.m., and then wheeled her out of the dining room. R40's meal lasted 44 minutes, and R40 ate approximately 90% of the meal.. R46's annual MDS dated 8/21/14, identified R46 was severely cognitively impaired and required extensive assistance with eating. During observation of the evening meal on 11/17/14, at 6:03 p.m. R46 was observed sitting at the dining room table with a plate of food and liquids in front of her. No staff were present at the table to assist R40 to eat until 49 minutes later, when trained medication aide (TMA)-A sat down and started to feed R46. R46 was taken out of the dining room at 6:57 p.m. R46's meal was in front of the resident for 49 minutes before receiving assistance to eat, and the resident ate approximately 10% of the meal. R58's quarterly MDS dated 10/2/14, identified R58 was severely cognitively impaired and required extensive assistance with eating. During observation of the evening meal on 11/17/14, at 6:03 p.m. R58 was observed sitting at the dining room table with a plate of food and a variety of liquids on the table in front of her. At	F 312	Policy and Procedure. The changes to these policies were reviewed with QA team. Audits will be conducted by the dietary manager or her delegate 8x/wk for one quarter to assure that compliance is maintained by staff. The results of these audits will be reviewed weekly during the IDT meeting and then reviewed with the QA team to evaluate the outcome from audits Corrective action was completed on 12/18/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312	Continued From page 63	F 312		

6:09 p.m. (6 minutes later) NA-A sat down next to R58 and gave her several bites of food. 3 minutes later, at 6:12 p.m., NA-A wheeled the stool she was sitting on to the other side of the table and began to feed another resident. At 6:41 p.m. (29 minutes later) TMA-A sat down and fed 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. During observation of the evening meal staff was not observed rewarming any resident meals.

The facility policy titled Feeding a resident dated 6/7/10, indicated residents were to be assisted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312	Continued From page 64 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.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review, the facility failed to evaluate/re-assess potential causative factors for multiple falls for 1 of 3 residents (R3) reviewed for accidents. Findings include: R3's annual Minimum Data Set (MDS) dated 9/18/14, indicated R3 had severe cognitive impairment, required assistance with all activities of daily living (ADL's), was frequently incontinent of urine, and was not on a scheduled toileting program. The falls Care Area Assessment (CAA) dated 10/1/14, indicated R3 had a history of falls, difficulty maintaining a sitting balance, and had an impaired balance during transition from sitting to standing. R3's care plan dated 5/30/14, directed staff R3	F 323	F323 Resident #3 was reassessed related to falls. New fall risk assessment completed with interventions added to care plan and Kardex. Resident did not sustain any residual effects from fall. Safety Risk Assessments completed on all residents in the facility. Care plans were reviewed and updated to include any added safety interventions. The new Safety Risk Assessments will be completed on admission, quarterly, with significant change and annually by licensed staff. Any safety intervention changes will be transferred onto resident care plan and kardex. The Resident Incident/Accident Policy and Procedure was reviewed and updated by the DON. A	12/12/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 65 required the assistance of staff with repositioning every two hours, offer/assist with toileting every two hours with rounds at night, and staff was to analyze previous falls to determine whether a pattern/trend could be addressed. The care plan did not instruct staff on any further fall interventions in place for R3. Review of the facility Incident Report Review/Investigation dated 9/7/14, indicated R3 had a fall at 10:20 p.m. The document indicated R3 was last checked at 10:00 p.m. during rounds and R3 was asleep, dry, and repositioned. The investigation information indicated all safety interventions were in place and the goal was to prevent injuries during self-transfer attempts and the resident had no injuries. There was no further investigation, no assessment regarding any current fall interventions that were in place to ensure they were appropriate, and no further interventions were put in place. Review of the facility Incident Report Review/Investigation dated 10/2/014, indicated R3 had a fall at 10:35 p.m. R3 had been checked on during rounds approximately 10 minutes earlier and was asleep at the time. The investigation indicated R3 was looking for her sister when R3 was restless, and R3 woke up after staff completed rounds. There was no further investigation, no assessment of any current fall interventions that were in place to ensure they were appropriate, and no further interventions were put in place. Review of the facility Incident Report Review/Investigation dated 11/5/14, indicated R3 had a fall at midnight. The investigation indicated R3 had removed the oxygen tubing from her nose	F 323	new Morning Stand-up Mtg log was developed and put into place to assure follow-up has been completed for resident specific issues. An intervention list for skin issues and falls was developed as a way to aide staff in implementation of safety interventions following incidents. All incidents and accidents are reviewed during daily Morning Stand-up Meeting. The members present at the meeting will review current safety interventions in place for the identified resident and assure that new interventions are added at the conclusion of the meeting. The facility administrator will audit all resident incident/accident reports weekly on an ongoing basis to assure that all incidents/accidents have been thoroughly reviewed and investigated. All incidents/accidents will be reviewed during weekly IDT as well to review the incident, investigation, and interventions that were put into place. A log of all incidents and accidents will be reviewed every quarter at the QA meeting. This will assure compliance with the implementation of new interventions with incidents and to assure that all incidents and accidents are investigated thoroughly. Any incidents that are the result of neglect, abuse, or maltreatment will be reported to the state reporting agency immediately by the licensed staff and then to the administrator and DON. The corrective action for this tag was completed on 12/12/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 66	F 323		

and crawled out of bed. The fall resulted in bruising to R3's right hand, wrist, and elbow. There was no further investigation, no assessment of any current fall interventions that were in place to ensure they were appropriate, and no further interventions were put in place. The investigation did not include when R3 was last toileted or repositioned, to determine if there was a trend with the other previous falls.

During observation on 11/18/14, at 3:48 p.m. R3 was sitting in her wheelchair in her room looking out the window.

During interview on 11/20/14, at 9:41 a.m. registered nurse (RN)-C stated R3 had climbed out of bed on 11/5/14, and gets restless and takes off the oxygen tubing and self-transfers out of bed.

During interview on 11/20/14, at 11:14 a.m. nursing assistant (NA)-C stated R3 did not have any falls or attempts to get up out of bed during the day shift.

During interview on 11/20/14, at 2:01 p.m. RN-B stated there were no new interventions put in place after R3's falls, and there was no assessment regarding any trends of R3's fall. RN-B stated R3 had medication to improve comfort and decrease restlessness/agitation/anxiety, but RN-B was unable to determine if those had been helpful.

During interview on 11/20/14, at 4:09 p.m. RN-A stated staff do rounds on R3 every two hours, which would possibly correlate with R3's falls, and stated that should be looked at to see if there is a trend of R3 falling after staff had done rounds and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 323	Continued From page 67 woke R3 up. RN-A stated R3's fall investigations were not thorough, and the investigations of the falls could be improved. The facility policy Resident Incident/Accident dated 4/16/14, directed licensed staff to conduct an investigation into the cause of the accident/incident, and an attempt to identify the root cause of the incident will be made.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 3 residents with significant weight loss (R21 and R50) were comprehensively assessed to ensure nutritional needs were met. Findings include: R21 sustained significant weight loss and developed multiple pressure ulcers, however no reassessment of R21's nutritional status was completed.	F 325	F325: Residents 21 and 50 had a new nutrition assessment completed by dietary manager. Corresponding updates have been made to the care plan and kardex. All residents in facility were reviewed for weight loss according to facility policy. Staff education was completed to ensure	12/18/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 325	Continued From page 68 R21 was admitted to the facility on 9/15/14, and had an admission Minimum Data Set (MDS) 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 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 assessment or interventions. The left heel wounds were assessed on 10/27/14, 11/3/14, and 11/6/14. Each assessment noted	F 325	that all staff were aware of appropriate dining room conduct and providing dining room assist to residents in a dignified manner. Registered dietician assisted with the revision of the Significant Weight Loss and Dining and Food Service Policy and Procedure. The changes to these policies were reviewed with QA team. Education was provided to dietary manager and IDT team on policy changes. Weight loss will be reviewed weekly by the dietary manager and will be discussed with IDT team. The results of weight loss reports will be reviewed weekly during the IDT meeting and then reviewed with the QA team to evaluate the adherence to facility policy. Corrective action was completed on 12/18/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 69	F 325		

the left heel wounds to be stage one, and the interventions remained unchanged.

On 11/14/14 the Wound Assessment/Monitoring form noted the left heel wounds to have declined to an untraceable level. The interventions of continuing to float heels while in bed and in wheelchair remained unchanged. Although the facility identified the pressure ulcers had gotten worse indicating they were now unstageable, no interventions were changed, including contacting dietary to ensure appropriate nutrition to encourage healing.

R21's documented weights included the following:
9/17/14 159 pounds
- 10/1/14 156.5 pounds
- 10/8/14 156 pounds
- 10/15/14 151.5 pounds
- 10/22/14 149.5 pounds which was flagged as a 6% decrease from 159 pounds
- 10/29/14 148.5 pounds which was also flagged as a 5.1% decrease from 156.5 pounds
- 11/12/14 148 pounds
- 11/19/14 146 pounds which flagged as 8.2% weight loss from 159 or 13 pounds

During interview on 11/20/14, at 9:14 a.m. dietary manager (DM)-A stated nursing staff would notify her if a resident had developed a pressure ulcer and she would complete the nutritional assessments to ensure the resident had appropriate nutritional interventions in place to promote healing. DM-A stated any resident identified at nutritional high risk would be reviewed by the consulting dietician. DM-A stated the computer system would trigger a notification for her when a resident's weight dropped 5% or greater. DM-A stated R21 had first triggered for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 325		F 325		

Continued From page 70
weight loss on 10/22/14, with a loss of 6% and she had been notified of the developed stage one pressure ulcers on 10/20/14. DM confirmed although R21 had a weight loss of >5%, and had developed multiple pressure ulcers, no reassessment of R21's nutritional status had been completed, nor had any interventions been put into place nutritionally to prevent further weight loss or aid in wound healing. DM stated, "It got missed."

During interview on 11/20/14, at 9:26 a.m. registered nurse (RN)-D stated no reassessment had been completed of R21's nutritional status after the weight loss or the development of the pressure ulcers. RN-D stated a supplement had just been started on 11/17/14, "After I talked to you on Monday, I realized that I had not started [R21] on a supplement." RN-D was unable to find any documentation in R21's record which indicated the dietician had been consulted regarding R21's weight loss or worsening pressure ulcers. RN-D stated the RN's on the floor were the ones responsible for completing the Wound Assessment/Monitoring forms. Upon review of the 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 they should have been staged at a stage two. In addition, RN-D stated she had not been notified when R21's pressure ulcers had been noted to go from stage one to unstageable.

During interview on 11/20/14, at 10:46 a.m. consulting dietician (D)-A stated she visited the facility monthly or bi-monthly if the census was low. D-A stated she would expect to be notified if a resident had a 5% or greater weight loss, or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 325 Continued From page 71 F 325

had developed a pressure ulcer.

During follow up interview on 11/20/14, at 1:41 p.m. 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 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 been 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 325	Continued From page 72	F 325		

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 indicated the following:

11/18/2014 - 136.0 lbs
11/11/2014 - 136.0 lbs
11/4/2014 - 135.0 lbs
10/28/2014 - 134.5 lbs
10/21/2014 - 137.5 lbs
10/14/2014 - 140.0 lbs
10/7/2014 - 142.5 lbs
9/30/2014 - 145.0 lbs

During observation on 11/19/2014, at 7:51 a.m. 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.

During interview on 11/20/2014, at 10:58 a.m. D-A stated she came to the facility monthly and the nurses maintained a list of which residents were on supplements. D-A stated the nurses would discontinue nutritional supplements for residents if they were eating well because of budget concerns. D-A stated nurses were responsible to flag residents with weight loss for D-A to review, and the D-M monitored the weights. D-A stated she was not made aware of R50's 9 pound weight loss in the past 45 days, and she would look at possible restarting R50's Boost supplement.

During interview on 11/20/14, at 4:29 p.m. RN-B stated R50's nutritional supplement had been discontinued a little over a month ago because

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 73	F 325		

the resident had been eating all of his meals, however, RN-B stated R50's nutritional supplement was being restarted today related to his recent weight loss.

During interview on 11/21/14, at 9:08 a.m. the DM stated R50 was taken off the supplement because he had gained weight. She stated R50's 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	**11/24/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 74 · Assess the risk of malnutrition. Identify potential causes.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 residents (R1) who received multiple psychoactive drugs (medications that have significant effect on mood and behavior) had clear indications for use. In	F 329	F329 Staff reviewed resident #1 s current list of medications and care plan. In error, incorrect diagnosis was in place for Gabapentin. Chart and MD notes	12/16/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 329

Continued From page 75

addition, the facility failed to ensure 1 of 1 discharged residents (R72) with multiple pain medication orders had appropriate parameters for use.

Findings include:

R1's quarterly Minimum Data Set (MDS), dated 10/23/14, identified the resident had no cognitive impairment, had a PHQ-9 (a test to determine depression severity) score of 2 (minimal depression), and exhibited no behaviors.

R1's care area assessment (CAA) for psychoactive drug use dated 5/16/14, indicated R1 had a history of psychiatric illness and was prone to crying and anxiety, and Cymbalta [an antidepressant] was helpful.

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 orders, dated 11/21/14, identified current medication orders including:

Abilify (an antipsychotic medication) 10 milligrams (mg) every day at bedtime for dementia/schizophrenia
Buspar (an anxiolytic) 20 mg twice daily for anxiety
Clonazepam (an anxiolytic) 0.5 mg three times daily for anxiety/dementia

F 329

reviewed and correct diagnosis was placed. Resident was seen on 11/26/14 by primary MD. All medications were reviewed. Dose reduction on one of resident s psychotropic medications was completed. Daily charting on mood/behaviors initiated for licensed staff to monitor toleration of reduction.

Resident #72 had been discharged on 11/4/14. With record review, it was noted that resident was on 2 different analgesics without guidelines as to which medication to use or how many tabs to administer. No harm was caused to resident during the short term rehabilitation stay but no guidelines were given by the primary MD for type of analgesic to use first or with different rates of pain.

Psychoactive med audit completed on all residents in facility to assure psychotropic medications had received dose reductions or appropriate documentation from primary MD for justification for use. Audits were also completed on all residents in facility to assure that any residents on multiple analgesics with variable dose ranges had appropriate guidelines for administration.

The DON reviewed and reviewed and revised the Psychotherapeutic Medication Policy and Procedure. Policy changes were reviewed with medical director and pharmacy consultant during quarterly QA meeting. All licensed nursing staff have been made aware and have been educated on policy and procedure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 329

Continued From page 76

Cymbalta (an antidepressant) 60 mg every day for anxiety/depression/peripheral neuropathy
Gabapentin (an anticonvulsant/analgesic) 300 mg by mouth twice daily for dementia/schizophrenia in the morning and evening, and an additional 200 mg daily at 1 p.m.
Klonopin (an anxiolytic) 0.5 mg by mouth daily as needed for anxiety
Zoloft (an antidepressant) 75 mg by mouth every day for anxiety/depression

Review of R1's behavior monitoring sheets for October- November 2014, indicated two episodes of feeling anxious, and one episode of irritability, both were redirectable with 1:1 visits or distraction.

During observation on 11/17/14, at 2:20 p.m. R1 was observed in bed. R1 had a flat facial affect but was alert and attentive, and displayed no adverse behaviors. She did not express any feelings of emotional distress.

During observation on 11/18/14, at 2:35 p.m. R1 was in the dayroom watching television. She had a flat facial expression, was alert, and displayed no adverse behaviors.

During interview on 11/18/14, at 3:26 p.m. NA-A and NA-D stated R1 did not have a lot of behaviors, only occasional tearfulness.

During interview on 11/20/14, at 11:18 a.m., registered nurse (RN)-C stated R1 did not display any behaviors and was set in her routine.

During interview on 11/20/2014, at 4:11p.m., the consultant pharmacist (CP)-A stated there were some "legitimate concerns" with the diagnosis or

F 329

changes.

Facility Health Unit Coordinator will review on all new orders and log any orders that require added clarification to assure that guidelines are in place on all medications with ranges and that appropriate diagnosis(es) are attached to all medications. Any concerns or inadequate documentation will be brought up to the licensed nursing staff and order clarification will be obtained when required.

The Director of Nursing will monitor the psychotropic use in the building. All new orders will be audited by the Health Unit Coordinator for the inclusion of parameters and diagnosis.
The Director of Nursing will be responsible for facility compliance.

Correction for this tag was completed 12/16/14.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 77 indications for use for R1's multiple psychoactive drugs. CP-A stated the medication indications needed to be more defined as to exactly what condition was being treated as there were multiple diagnoses listed for the medications, and further stated Gabapentin for schizophrenia would "never fly," indicating it was not an appropriate diagnoses. CP-A stated there was another pharmacist that came to the building more often, and he would have that pharmacist return a call. During interview on 11/20/2014, at 4:16 p.m. RN-B stated R1 was doing well right now with her behaviors and did show some perseveration on a topic and will not let it go. Her behaviors did not disrupt her daily routine. During interview on 11/21/14, at 10:25 a.m. CP-B, who was the regularly scheduled consultant pharmacist for the facility, stated she monitored R1's medication effectiveness through "trial and error," as there were multiple diagnoses and duplicate medication class therapy for some of the psychoactive drugs. The facility policy titled Psychotherapeutic Medications dated 3/4/13, indicated a resident will not receive psychotherapeutic medications unless such a medication is needed to treat a specific condition, and each psychotherapeutic medication will be given to treat clearly defined target behaviors. The policy further stated duplicative drug therapy would be closely monitored and discouraged. R72's admission progress note dated 11/5/14, indicated the resident was admitted to the facility	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329		F 329		

Continued From page 78

to recover after fracturing the coccyx. R72's admission minimum data set (MDS) dated 11/11/14, identified R72 had no cognitive impairment, had been receiving PRN (as needed) pain medication, and had frequent pain.

R72's current care plan dated 11/14/14, instructed staff to ask the resident about pain and offer analgesia at least 30 minutes prior to therapy.

R72's Pain Assessment dated 11/4/14, indicated the resident had constant pain at all times, and was using PRN pain medications of Norco 5-325 mg, 1-2 tabs every 4 hours, and Tylenol 1000 mg every 6 hours. The summary of R72's pain assessment was, "...has PRN Norco and Tylenol for pain... Did explain the use of PRN medication to [R72] and staff are to monitor her for non verbal and verbal cues to pain..."

R72's current physician orders dated 11/14/14, indicated R72 was prescribed the following PRN pain medications:

- Norco (Hydrocodone- Acetaminophen) 3-325 mg tablet PRN, 1-2 tablets, every 4 hours for pain.
- Tylenol Extra Strength (Acetaminophen) 1000 mg tablet PRN, Every 6 hours for pain.

R72's physician orders did not include parameters which directed staff when R72 was to receive Tylenol vs Norco, nor did it instruct staff when to administer one or two tablets of Norco.

Review of R72's Medication Administration Record (MAR) for November 2014, indicated from 11/5/14- 11/18/14, R72 received 43 doses of Norco. Of the 43 separate administration times, R72 received 2 tablets of Norco 40 times, and 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 79 tablet of Norco 3 times. On 11/9/14, R72 received Tylenol 1000 mg, as well as two doses of Norco, 2 tablets. On 11/10/14, R72 received Tylenol 1000 mg, as well as two doses of Norco, 2 tablets. During interview on 11/20/14, at 9:55 a.m. RN-B stated when residents are admitted with medication orders that included ranges, such as taking 1-2 tablets, the nursing staff should call the physician to obtain specific orders to ensure staff know what actual dose of Norco the resident should receive, or else the consulting pharmacist usually will catch it when doing the pharmacy review, however, R72 had not yet had a pharmacy review of medications since admission to the facility. RN-B stated R72's Norco order should have instructed when R72 should receive one Norco or two, as well as when the resident should receive Tylenol vs Norco. During interview on 11/20/14, at 10:10 a.m. licensed practical nurse (LPN)-B stated when she administered R72 Norco, she usually just gave her 2 tablets because the resident was having significant pain. LPN-B stated when residents have PRN pain medication orders, usually there is an order which instructs staff on how much pain medication to give depending on the residents range of pain, however, R72 did not have specific orders, so the nurses just administered the pain medication according to how the resident was doing on a specific day. A policy on medication range orders was requested, but not provided.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		12/11/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 80 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain the ice machine in a sanitary manner to minimize the possibility of food borne illness. This had the potential to affect all 36 residents currently residing in the facility who received ice on a daily basis from the ice machine. Findings include: During the initial kitchen tour on 11/17/14, at 12:32 p.m. an ice machine was observed just outside the kitchen, in the facility dining room. Inside the ice machine, a green substance was observed covering the components in the top right corner where the ice was made. The green substance covered the water pump, water trough, ice damper, distribution tube, and evaporator. In addition, there were two trickles of the green substance which ran from the components down the back panel and disappeared behind the already made ice sitting in the ice machine. The dietary manager (DM) verified the green substance, and stated the ice machine had just been moved to the dining room from the assisted	F 371	F371 Upon notification of concerns with facility ice machine, the maintenance director cleaned and sanitized the facility ice machine. All residents who had water delivered the morning of 11/18/14, had their water glasses replaced and filled with clean ice after the ice machine was cleaned. No harm or illness resulted from the issue. Ice Machine Cleaning Policy and Procedure was developed. The manufacturer s guide specific to the ice machine was connected and placed on the rear of the ice machine. Manufacturer s guidelines recommends cleaning every 6 months. Maintenance director developed audit log and will be cleaning facility ice machine every quarter which is actually more frequently than manufacturer s guidelines. This audit is also attached to the rear of the ice	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 81 living building on 11/14/14, so there was not a cleaning schedule set up yet. During interview on 11/17/14, at 1:29 p.m. Maintenance (M)-A stated the ice machine was moved in the dining room at the facility on 11/14/14. M-A stated when he brought the ice machine to the facility and installed it in the dining room, he rinsed the machine quickly with bleach, but did not take it apart, made no attempts to scrub off the green substance. M-A thought the green substance was a copper build up, but wasn't 100% certain. During a follow up observation on 11/18/14, at 10:37 a.m. the green substance was still present in the ice machine. The green substance in the ice machine was touched with a gloved hand, and the substance was able to be rubbed off and turned the finger of the white glove green, and the green substance was able to be removed just by touching it. M-A removed the machine from service to clean, and the ice that had been given to the residents earlier in the day in pitchers of water in their room, were removed from their rooms. Review of the Manitowoc (ice machine manufacturer) Installation, Use and Care Manual dated 2/10, indicated recommendations the machine be cleaned and sanitized every six months and must be taken apart for cleaning and sanitizing. Review of the undated facility's policy titled Production, Storage, and Dispensing of Ice indicated manufacturer's guidelines for cleaning should be used. The policy further indicated all surfaces should be scrubbed with particular attention to door tracks, guides and gaskets.	F 371	machine. The changes and implementation of the new cleaning policy was reviewed during the QA meeting. Corrective action for this tag was completed on 12/11/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

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F 425	Continued From page 82	F 425		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 2 residents, (R25, R37) who received a fentanyl patch (a narcotic pain medication) had consistent and accurate administration and destruction plan to ensure the resident was receiving the medication as prescribed, as well to ensure the fentanyl patches were destroyed to prevent possible diversion. Findings include:	F 425	F425 On 12/16/14, the pharmacy consultant was in building for monthly visit and reviewed narcotic ledger for accuracy of Fentanyl patches. All recent entries on resident #25 and 37 involving Fentanyl had appropriate documentation including double signatures. No irregularities were noted on recent Fentanyl entries. Resident #37 was discharged to an assisted living facility on 12/12/14.	12/5/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

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F 425

Continued From page 83

R25's quarterly Minimum Data Set (MDS) dated 10/16/14, identified the resident had severe cognitive impairment, was on scheduled pain medication, and had no signs or symptoms of pain.

R25's current physician orders dated 11/17/14, indicated Fentanyl 25 mcg patch every 72 hours for pain. The Fentanyl prescription was started on 2/5/13.

Review of R25's Individual Narcotic Record indicated a Fentanyl patch was administered on 1/25/14, and the next patch was not administered until 1/30/14, five days later. However, R25's Medication Administration Record (MAR), indicated R25 received a Fentanyl patch on 1/25/14, 1/28/14, and 1/30/14.

During interview on 11/20/14, at 10:15 a.m. registered nurse (RN)-A stated she was unsure why R25's narcotic record and MAR did not match indicating when the resident actually received the Fentanyl patch. RN-A stated there was no medication error report for R25, and stated the Fentanyl patch counts for the facility had not been off.

R37's admission MDS dated 9/15/14, identified the resident had moderate cognitive impairment, was on a scheduled and PRN (as needed) pain medication, and had moderate, frequent pain.

R37's current physician orders dated 11/19/14, indicated Fentanyl 25 mcg patch every 72 hours for pain.

Review of R37's Individual Narcotic Record indicated a Fentanyl patch was administered on

F 425

On 12/16/14 the pharmacy consultant audited all residents in the facility receiving Fentanyl. No other recent irregularities or concerns were noted.

The DON reviewed and reviewed and revised the Medication Error Policy and Procedure on 12/1/14 and Daily Narcotic Medication Count and Use of Narcotic Patches Policy and Procedure on 12/5/14. Pharmacy consultant and medical director present for Quarterly QA meeting on 12/16/14. Changes in the policies were reviewed. A new Medication Error Report was developed and put into use on 12/5/14. This new form will allow the staff member making error to review and sign off that the error has been acknowledged and education was given. Licensed staff have been education on new policy and procedures changes related to medication errors and fentanyl documentation.

Facility staff review narcotic counts and review bound narcotic ledger each shift daily. The Pharmacy Consultant will audit the facility bound narcotic ledgers every month to assure that the documentation related to administration and destruction policies of fentanyl continues to be followed by facility staff. Any discrepancies in medication errors will be brought to the attention of the DON and appropriate follow up, investigation, education, etc per medication error will occur.

The corrective action for this tag was completed on 12/5/14.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 425	Continued From page 84	F 425		

9/14/14, and the next patch was not administered until 9/20/14, six days later. R37 received a Fentanyl patch on 10/9/14, and the next patch was not administered until 10/13/14, four days later. The Fentanyl patches were also not signed off by two nurses when destroyed per facility policy on 9/8/14, 9/26/14, 10/2/14. On 10/13/14, there was only one nurse's signature, and written next to it was, "No patch to remove."

Review of R37's MAR for September 2014, indicated the resident received a Fentanyl patch on 9/14/14, and did not receive the next patch until 9/20/14, six days later. R37's MAR for October 2014, indicated R37 received a Fentanyl patch on 10/8/14, 10/9/14, 10/12/14, and again on 10/13/14.

The facility provided two Medication Error forms for R37 which identified the following:

10/12/14- "Fentanyl patch due to be changed on 10/12/14. No patch available to apply... Patches were not reordered when last patch was applied..."
10/19/14- "During AM (morning) cares resident's Fentanyl patch from 10/9/14, was still on resident's left shoulder..."

During interview on 11/20/14, at 10:15 a.m. RN-A stated R37 was to have a Fentanyl patch applied every 72 hours for pain. RN-A was unable to determine why the MAR and Narcotic record didn't match, and stated the nurses needed more training regarding documentation of administration and destruction of the Fentanyl patches. RN-A stated the facility nurses had training several months ago regarding destruction and administration of Fentanyl patches, and they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET** **OSAKIS, MN 56360**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 85 were instructed two nurses must witness and sign off the destruction of Fentanyl patches. RN-A stated the facility did not have a specific Fentanyl patch destruction policy, however, the facility had a policy on destroying all medications with a witness. During interview on 11/26/14, at 10:00 a.m. consulting pharmacist (CP)- G stated when she goes to the facility, she reviews the current Fentanyl patch count along with the Narcotic Book, to ensure the Fentanyl patch count is correct. CP-G stated with the current documentation system, it is difficult to determine when the resident actually received the patch. CP-G stated two nurses should be signing off when a Fentanyl patch is removed from a resident and destroyed, and she plans on doing more education for the facility regarding documentation and destruction of Fentanyl patches. 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.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		12/16/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 86	F 428		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review the consultant pharmacist (CP) failed to identify and forward irregularities to the attending physician for 1 of 1 residents (R1) reviewed for unnecessary medication who received multiple psychoactive drugs (medications that have significant effect on mood and behavior) who lacked clear indications for use.

Findings include:

R1's quarterly Minimum Data Set (MDS), dated 10/23/14, identified the resident had no cognitive impairment, had a PHQ-9 (a test to determine depression severity) score of 2 (minimal depression), and exhibited no behaviors.

R1's care area assessment (CAA) for psychoactive drug use dated 5/16/14, indicated R1 had a history of psychiatric illness and was prone to crying and anxiety, and Cymbalta [an antidepressant] was helpful.

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.

F428
Staff reviewed resident #1 s current list of medications and care plan. In error, incorrect diagnosis was in place for Gabapentin. Chart and MD notes reviewed and correct diagnosis was placed. Resident was seen on 11/26/14 by primary MD. All medications were reviewed. Dose reduction on one of resident s psychotropic medications was completed. Daily charting on mood/behaviors initiated for licensed staff to monitor toleration of reduction.
Psychoactive med audit completed on all residents in facility to assure psychotropic medications had received dose reductions or appropriate documentation from primary MD for justification for use. Audits were also completed on all residents in facility to assure that any residents on multiple analgesics with variable dose ranges had appropriate guidelines for administration.
The DON reviewed and reviewed and revised the Psychotherapeutic Medication Policy and Procedure. Policy changes were reviewed with medical director and pharmacy consultant during quarterly QA meeting. All licensed nursing staff have been made aware and have been educated on policy and procedure changes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

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F 428

Continued From page 87

R1's physician orders, dated 11/21/14, identified current medication orders including:

Abilify (an antipsychotic medication) 10 milligrams (mg) every day at bedtime for dementia/schizophrenia
Buspar (an anxiolytic) 20 mg twice daily for anxiety
Clonazepam (an anxiolytic) 0.5 mg three times daily for anxiety/dementia
Cymbalta (an antidepressant) 60 mg every day for anxiety/depression/peripheral neuropathy
Gabapentin (an anticonvulsant/analgesic) 300 mg by mouth twice daily for dementia/schizophrenia in the morning and evening, and an additional 200 mg daily at 1 p.m.
Klonopin (an anxiolytic) 0.5 mg by mouth daily as needed for anxiety
Zoloft (an antidepressant) 75 mg by mouth every day for anxiety/depression

R1's pharmacy consultant reviews for the previous seven months indicated irregularities identified on 10/20/14, with relation to considering a dose reduction for R1's buspirone (an anxiolytic). No other irregularities were listed in relation to R1's multiple psychoactive medications.

Review of R1's behavior monitoring sheets for October- November 2014, indicated two episodes of feeling anxious, and one episode of irritability, both were redirectable with 1:1 visits or distraction.

During observation on 11/17/14, at 2:20 p.m. R1 was observed in bed. R1 had a flat facial affect but was alert and attentive, and displayed no

F 428

Facility Health Unit Coordinator will review on all new orders and log any orders that require added clarification to assure that guidelines are in place on all medications with ranges and that appropriate diagnosis(es) are attached to all medications. Any concerns or inadequate documentation will be brought up to the licensed nursing staff and order clarification will be obtained when required.
The Pharmacy Consultant will continue to review the drug regimen of all facility residents monthly with updates forthcoming to provider.
The Director of Nursing will be responsible for facility compliance.
Correction for this tag was completed 12/16/14.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

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F 428	Continued From page 88	F 428		

adverse behaviors. She did not express any feelings of emotional distress.

During observation on 11/18/14, at 2:35 p.m. R1 was in the dayroom watching television. She had a flat facial expression, was alert, and displayed no adverse behaviors.

During interview on 11/18/14, at 3:26 p.m. NA-A and NA-D stated R1 did not have a lot of behaviors, only occasional tearfulness.

During interview on 11/20/14, at 11:18 a.m., registered nurse (RN)-C stated R1 did not display any behaviors and was set in her routine.

During interview on 11/20/2014, at 4:11p.m., the consultant pharmacist (CP)-A stated there were some "legitimate concerns" with the diagnosis or indications for use for R1's multiple psychoactive drugs. CP-A stated the medication indications needed to be more defined as to exactly what condition was being treated as there were multiple diagnoses listed for the medications, and further stated Gabapentin for schizophrenia would "never fly," indicating it was not an appropriate diagnoses. CP-A stated there was another pharmacist that came to the building more often, and he would have that pharmacist return a call.

During interview on 11/20/2014, at 4:16 p.m. RN-B stated R1 was doing well right now with her behaviors and did show some perseveration on a topic and will not let it go. Her behaviors did not disrupt her daily routine.

During interview on 11/21/14, at 10:25 a.m. CP-B, who was the regularly scheduled consultant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 89 pharmacist for the facility, stated she monitored R1's medication effectiveness through "trial and error," as there were multiple diagnoses and duplicate medication class therapy for some of the psychoactive drugs. The facility policy titled Psychotherapeutic Medications dated 3/4/13, indicated a resident will not receive psychotherapeutic medications unless such a medication is needed to treat a specific condition, and each psychotherapeutic medication will be given to treat clearly defined target behaviors. The policy further stated duplicative drug therapy would be closely monitored and discouraged.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		12/5/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

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F 441	Continued From page 90 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to 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: R53's quarterly MDS dated 9/18/14, identified the resident required extensive assistance of two staff for personal hygiene and toileting. During observation on 11/19/14, at 8:12 a.m. the hospice nursing assistant (HNA) and nursing assistant (NA)-E were providing personal cares to R50. HNA emptied R50's urinary catheter bag into a urinal with gloved hands, dumped the urine in the toilet and rinsed the urinal with water, dumping the rinse water into the toilet. HNA then	F 441	F441 Residents #53, 47, and 16 have been reviewed for potential negative outcomes from the lack of proper handwashing witnessed on 11/18, 11/19 and 11/20/14. No adverse outcomes noted to the above 3 residents. Infection control reports reviewed on 12/16/14 and no trend of an increase in infections including UTI s or other illnesses in facility were noted. The Blood Glucose Policy and Procedure was reviewed and revised. The facility Hand-washing Policy and Procedure was reviewed but did not require any revisions. The quarterly QA team met on 12/16/14 and reviewed all infections in facility this past quarter. No increase in infections or	

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F 441 Continued From page 91

hung the urinal on the garbage can in the bathroom and removed her gloves. Without washing her hands, the HNA returned to the bedside and proceeded to help NA-E roll the resident side to side for peri care. NA-E applied gloves and took an incontinent wipe to cleanse R50's skin during peri-care. NA-E's gloves became visibly soiled with stool when wiping R50. After wiping R50, NA-E removed her gloves and threw them in the garbage. Without washing her hands, NA-E proceeded to hook R50 up in a mechanical lift sling, touching the sling, the resident's shoulders, and the shower chair during the process.

During interview on 11/19/14, at 8:25 a.m. NA-E confirmed she had not washed her hands after removing the soiled gloves and would wash her hands immediately after she left the room. The HNA stated she had, "thought about" removing her gloves after emptying R50's catheter bag of urine, however, had not done this and should have.

R47's quarterly Minimum Data Set (MDS) dated 8/18/14, identified R47 had severe cognitive impairment, required extensive assistance with all activities of daily living (ADL'S), and was incontinent of bowel and bladder,
During observation on 11/19/14, at 8:30 a.m. nursing assistant (NA)-F and NA-B were observed providing personal cares for R47. NA-F and NA-B had gloves on, and assisted R47 to turn on her right side, and NA-F pulled down R47's incontinent product. NA-F stated the incontinent product contained urine and stool, and NA-F used several disposable wipes to clean R47's perineal area, wiping R47 with her gloved left hand and then switched to wipe with the

F 441

trends was noted by the team and medical director.

Hand washing audits during cares, meals, and nursing treatments were put into place and continue to be ongoing as employees arrive for scheduled shifts. All employees will be audited to assure that hand washing is completed accurately and according to facility policy. 10 Hand washing audits will continue weekly for one quarter to assure that staff remain in compliance with hand washing policy. The results of the audits will be brought to and reviewed at the next QA meeting.

Education on Handwashing was provided to staff on 11/25 and 12/2/14. Hand washing audits during cares, meals, and nursing treatments were put into place and continue to be ongoing as employees arrive for scheduled shifts. These audits will be reviewed by the Director of Nursing weekly and the results brought to QA. All employees will be audited to assure that hand washing is completed accurately and according to facility policy. 10 Hand washing audits will continue weekly for one quarter to assure that staff remain in compliance with hand washing policy. The Director of Nursing is responsible for compliance.

Correction for this tag was completed on 12/5/14.

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F 441	Continued From page 92 gloved right hand. Without removing the visibly soiled gloves, NA-F opened the top drawer on R47's bedside stand, picked up a tube of ointment, unscrewed the cap of the tube, squeezed ointment from the tube into her right hand, replaced the 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 picked up the tube of ointment from the bed, opened the drawer, put the tube of ointment into the drawer, and pushed the drawer shut. Without removing the gloves, NA-F picked up the package of disposable wipes from the bed, and tossed them onto the bedside stand. NA-F removed the soiled glove on her right hand, and continued to assist to put R47's clean incontinent product on. NA-F then removed the left glove, and continued to assist NA-B to turn and dress R47. R47 was lying on top of a pad used to protect the bed, and although this pad was visibly soiled with stool, NA-F and NA-B pulled R47's pants up, sliding them across the soiled pad. NA-B removed her gloves, and NA-F and NA-B positioned R47 onto a canvas sling used for the transfer lift, touching the sling, the lift, R47's wheelchair and foot pedals, and the privacy curtain. R47 was transferred and positioned into the wheelchair. NA-F brushed R47's hair and put her glasses on. Without washing her hands, NA-F opened the door to R47's room touching the door handle, and then pushed R47 to the dining room in the wheelchair, touching both handles on the wheelchair. NA-F positioned R47 at the table, picked up the clothing protector, placed it on R47, and secured the clothing protector around R47's neck. NA-F walked back to R47's room, pulled the linens up on the bed, touched the pillow, straightened items on the bedside table, and picked up a bag that contained the soiled linens	F 441		

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F 441	Continued From page 93	F 441		

and a bag that contained the soiled incontinent product, and carried the two bags through the hallway, to a closed door that she opened, and then threw the bags into receptacles. After disposing of the bags, NA-F then used hand sanitizer to clean her hands.
During interview on 11/19/14, at 8:43 a.m. NA-F stated she touched many items with the soiled gloves during R47's cares and did not remove her gloves after providing personal cares. NA-F verified she did not wash her hands after removing her soiled gloves and before touching many items in R47's room, as well as outside of R47's room. NA-F stated she should have changed gloves after providing personal cares, and should have washed her hands after removing the gloves.
During interview on 11/20/14, at 1:50 p.m. registered nurse (RN)-B stated she had identified concerns with pericare and handwashing when the NA were providing care to residents, and she had re-posted the pericare and handwashing policy in the soiled utility room for the NA's to review. RN-B stated she would expect staff to change their gloves and wash their hands after cleaning a resident of bowel movement.

The facility policy titled Handwashing Policy dated 5/10/14, directed staff to wash hands after each contact with a resident, before serving food or helping residents eat, after removing gloves and other personal protective equipment, and after hand contact with blood or other potentially infectious materials.

During observation on 11/20/14, at 11:10 a.m. licensed practical nurse (LPN)-B performed a blood glucose check on R16. LPN-B wiped R16's finger with an alcohol wipe, punctured the

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F 441	Continued From page 94 finger with a lancet, placed a sample of blood on the test strip, and wiped the blood from R16's finger with a cotton ball. LPN-B was not wearing gloves during this time. After the results were read, LPN-B brought the glucometer, test strip, cotton ball, and lancet back to the medication/treatment cart, carrying the supplies in the left hand, and unlocked her cart with keys in her right hand. The items were disposed of, the glucometer was placed back in the cart, and LPN-B proceeded to enter data onto her computer on top of the cart without performing any hand hygiene. When interviewed on 11/20/14, at 3:30 p.m. LPN-B stated she would typically return to her cart, discard the soiled items appropriately, and perform hand hygiene prior to touching the computer. LPN-B verified she did not perform hand hygiene after performing R16's blood glucose testing. A facility policy regarding hand hygiene and blood glucose testing was requested but not provided.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure resident wheelchairs were clean for 1 of 1 residents (R21)	F 465	F465 The wheelchair armrest for R47 was	12/16/14

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F 465	Continued From page 95 observed with a soiled wheelchair. In addition, the facility failed to ensure wheelchairs were in good repair for 1 of 1 resident (R47) observed with a torn armrest. Findings include: On 11/18/14, at 9:35 a.m. R21's wheelchair was noted to be full of debris and crumbs on the pad of the wheelchair, appeared soiled on the right hand corner. On 11/20/14, at 10:58 a.m. R21 observed sitting in the wheelchair in the activities area. Debris and dust were noted below the seat of the wheelchair. On 11/20/14, at 1:40 p.m. maintenance (M)-A observed R21's wheelchair and verified there was dirt and debris present. After consulting with housekeeping, a copy of the Wheelchair Washing Log (West) was provided for October, November, and December 2014, which indicated all resident wheelchairs were to be washed twice a month on the cleaning schedule. R21's wheelchair had no documentation of being cleaned / washed during October or November. A copy of the Twice a Month Wheelchair Washing Log (West) was requested and received for May 2014 through September 2014, and the last documented washing of R21's wheelchair was on 9/18/14. M-A verified housekeeping should be cleaning/washing the wheelchairs twice per month per policy, and if they are heavily soiled, they are brought to maintenance to take apart and clean. M-A stated he has not done cleaning on R21's wheelchair. The undated facility policy titled Wheelchair	F 465	replaced on 11/24/14 by the maintenance director. The wheelchair of R21 was immediately cleaned following soil identification. All resident rooms and equipment were visually inspected by the housekeeping and maintenance staff. The policy and procedure for wheelchair washing was revised and a cleaning check list for the Housekeeping staff was revised to include the cleaning of the wheelchairs. The policy for Cleaning and Maintenance for CMH resident rooms for annual and daily maintenance was also modified. The CMH policy was modified on to include equipment repair and maintenance, procedure and preventative maintenance. These policies were approved at the QA meeting on 12/16/14. The maintenance director will audit the cleaning logs weekly for a quarter to assure compliance with the updated policy and procedure. The results of these audits will be reviewed at QA. The Director of Maintenance is responsible for compliance. Corrective Action Completed: 12/16/14	

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F 465	Continued From page 96 washing indicated all wheelchairs within the nursing home shall be inspected each shift, wiped down as needed, and washed at least twice a month according to the wheelchair washing schedule. During observation on 11/20/2014, at 10:30 a.m. R47's wheelchair was observed with a torn left armrest, with exposed foam which created an uncleanable surface. During observation on 11/21/2014, 9:30 a.m. R47's wheelchair was again observed with exposed foam on the left arm rest which was also noted to be frayed. During interview on 11/24/2014, at 12:26 p.m. M-A stated R47's wheelchair needed new armrests and he tried to visually inspect all resident equipment in disrepair which would require repairs, however, there was no maintence schedule of inspection. MA-A stated staff were to notify him if they saw any equipment that needed to be fixed. During interview on 11/21/2014, at 2:03 p.m. the administrator stated the facility maintenance staff monitored for equipment in disrepair and dealt with issues as soon as they became aware of them. He was unaware of any concerns with R47's wheelchair armrest that was torn and uncleanable. The undated facility policy titled Equipment Repair and Maintenance indicated maintenance would conduct monthly equipment checks and repair equipment as needed.	F 465		
F 490	483.75 EFFECTIVE	F 490		12/18/14

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F 490 SS=F	Continued From page 97 ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the administrator failed to adequately oversee and monitor care and services related to the development, implementation, and evaluation of abuse prohibition policies and procedures in the facility. This had the potential to affect all 36 residents currently residing in the facility. Findings include: Refer to F224, as the facility 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,	F 490	F490 It is the policy of CMH that our facility be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Vulnerable adult reports were filed to the state agency on residents #47 and #12 on 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 filed 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 further training on resident transfers and one employee required additional dementia education. The two employees that received further education were allowed to return to work after the education had been completed. All above residents affected had care plans reviewed. No adjustments were required. Mood/behavior focus charting was	

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F 490	Continued From page 98 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 currently residing in the facility. Refer to F226, as 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 when an investigation was taking place of potential mistreatment. This had the potential to affect all 36 residents currently residing in the facility. During interview on 11/19/14, at 12:10 a.m. administrator stated he felt like he was involved in the investigation process at the facility. The administrator stated he would expect if there was a complaint of resident mistreatment, the supervisor would listen to the complaint, evaluate it, investigate to the extent warranted immediately, and report to him, "Accordingly." The administrator stated he communicated with the DON about resident 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	F 490	initiated and completed on all residents #52, 58, 44, 47 and 12 to monitor for any changes in psychosocial wellbeing. No concerns or effects from the filed reports were noted. Interviews conducted with all nursing staff on 11/19/14 and interviews conducted with all residents in the facility on 11/20/14 to identify other potential cases of resident neglect or mistreatment. During resident interviews, one incident was reported. Incident was immediately reported to state agency. The incident was then investigated per Vulnerable Adult Policy and procedures. Staff member involved was suspended and received additional training on transfers prior to her return to work schedule. Safety Risk assessments were completed on all residents and care plan changes were adjusted. Zero Tolerance statement initiated by facility administrator. Vulnerable Adult Policy and Procedure was reviewed and revised to include the protection of residents during an alleged act of abuse/neglect. Changes include immediate removal and/or suspension of alleged perpetrator. All licensed staff received training and direction on how to submit an alleged report of abuse to the state agency. An in-service training by a trained consultant was conducted for staff on Vulnerable Adult and Abuse. This education included reviewing the hard copy of the updated Vulnerable Adult Abuse and Prevention Plan, an in-depth discussion on different types of abuse	

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F 490	Continued From page 99 believed the facility understood the process of investigation, reporting, and resident protection, however, not all allegations of mistreatment, "Result in injury." The administrator also stated he was aware residents have felt that staffs communication with them have been, "Less then desired by the resident." The administrator stated staff are aware the need to report to the administrator immediately any allegations of resident mistreatment. He stated, "If it gets to me, if it rises to the level of mistreatment, we 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. During a follow up interview on 11/21/14, at 1:47 p.m. the administrator stated the facility had been focused on injuries of unknown origin, and assisting staff to recognize bruising injuries to residents, and when to report them. Reporting and recognition of other types of potential abuse had not been a focus.	F 490	including examples of physical, verbal, and emotional abuse. The staff were also educated on the new disciplinary procedures during reports of alleged abuse. The new Abuse Protocol folders were also reviewed and the contents of them were discussed at the inservice. The director of nursing conducted 2 staff meetings to review Vulnerable Adult policy and procedures. Policy and Procedures of Morning Standup, Weekly IDT, and Quality Assurance were reviewed and revised to include added communication and review of incidents and Vulnerable Adult trends. Grievances and or incidents will be reviewed on a daily basis during the Morning Standup Meeting and weekly with the IDT team which is led by the facility administrator. All unresolved grievances will be reviewed quarterly with the QA team for further review and direction for resolution. An incident log was developed and put into place by the Director of Nursing. All incidents will be reviewed during Morning Standup and then the incident will be placed on the log record. The log will be reviewed weekly during IDT and quarterly with QA to assure that all incidents are fully investigated and complete. A new grievance form was developed and put onto place. Staff were educated by the director of nursing on the location and proper use of the new facility grievance forms. Staff education of Vulnerable Adult Policy and Procedure will continue through	

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F 490	Continued From page 100	F 490	QAPI. During resident council on 12/18/14, a review of Vulnerable Adult Policy and Procedure and grievance procedure took place. All IDT weekly log minutes will be reviewed quarterly with the QA team to review incidents and potential trends of abuse. Upon this review system revisions and/or staff education will be implemented indicated via proscribed written action plan. New employee hire packets and education were updated to include revisions to Vulnerable adult policy and procedures. Quarterly resident interviews will be conducted by social services or her delegate to facilitate the identification of any actual or potential issues. Quarterly QA meeting occurred on 12/16/14. New changes related to the Vulnerable Adult Policy and Procedure were reviewed with the medical director. The Administrator will attend morning standup meeting as well as weekly IDT. A review of policies by the Medical Director was completed during QA to ensure current standards of practice are in place. Staff members, including administration were trained as it relates to their respective roles and responsibilities regarding the policy and procedures on 12/16/14. The Board of Directors will be responsible for compliance. Corrective action for this tag has been completed on 12/18/14.	
F 493	483.75(d)(1)-(2) GOVERNING BODY-FACILITY	F 493		12/18/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 493 SS=F	Continued From page 101 POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's governing body failed to ensure adequate oversight of managerial staff and facility practices related to implementation and development of abuse prohibition policies and practices to ensure the health and safety of all residents. This deficient practice had the potential to affect all 36 residents currently residing in the facility. Findings include: Refer to F224, as the facility 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	F 493	F493 It is the policy of Community Memorial Home to have a governing body, or designated persons func-tioning as a governing body, that is legally responsible for establishing and implementing policies re-garding the management and operation of the facility; and the governing body appoints the administra-tor who is licensed by the state where licensing is required; and responsible for the management of the facility. In response to F224, F225, F226, F490, F501 and F520 : Vulnerable adult reports were filed to the state agency on residents #47 and #12 on 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 filed 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 further	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 493

Continued From page 102

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 currently residing in the facility.

Refer to F226, as 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 when an investigation was taking place of potential mistreatment. This had the potential to affect all 36 residents currently residing in the facility.

Refer to F490, as the administrator failed to adequately oversee and monitor care and services related to the development, implementation and evaluation of abuse prohibition policies and procedures in the facility.

Refer to F501, as the facility medical director failed to provide guidance and collaboration with

F 493

training on resi-dent transfers and one employee required additional dementia education. The two employees that re-ceived further education were allowed to return to work after the education had been completed. All above residents affected had care plans reviewed. No adjustments were required. Mood/behavior focus charting was initiated and completed on all residents #52, 58, 44, 47 and 12 to monitor for any changes in psychosocial wellbeing. No concerns or effects from the filed reports were noted.

Interviews conducted with all nursing staff on 11/19/14 and interviews conducted with all residents in the facility on 11/20/14 to identify other potential cases of resident neglect or mistreatment. During resident interviews, one incident was reported. Incident was immediately reported to state agency. The incident was then investigated per Vulnerable Adult Policy and procedures. Staff member involved was suspended and received additional training on transfers prior to her return to work schedule. Safety Risk assessments were completed on all residents and care plan changes were adjusted.

Zero Tolerance statement initiated by facility administrator. Vulnerable Adult Policy and Procedure was reviewed and revised to include the protection of residents during an alleged act of abuse/neglect. Changes include immediate removal and/or suspension of alleged perpetrator. All licensed staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 493

Continued From page 103

the facility staff related to development, implementation, and evaluation of abuse prohibition policies and procedures in the facility.

Refer to F520, as the facility quality assurance committee failed to identify and develop a plan of action to address concerns related to development, implementation, and evaluation of abuse prohibition policies and procedures in the facility.

During interview on 11/24/14, at 1:21 p.m. the governing board president (GP) stated the board typically discussed disciplinary issues, such as terminations, at their monthly meetings. The board was aware of the current issues related to abuse prohibition policies and practices within the facility, and had been aware of issues during the prior survey in April 2014, also related to abuse and mistreatment of residents. The GP stated this was something they wanted addressed and had always been supportive of staff in doing their job, however, GP stated they were unaware of any current concerns with managerial staff or any other personnel at this time related to facility abuse accusations against staff.

The facility incorporation articles titled Community Memorial nursing Home at Osakis, Minnesota, Incorporated dated 8/12/1986, indicated the purpose of this corporation shall be to construct, equip, and operate facilities for the care of the sick and aged, including, but not limited to a nursing home, or boarding home, and to any and all necessary acts for the accomplishment of this purpose. The articles also provided for a Board of Directors and indicated the business and property of the corporation shall be managed by its Board of Directors.

F 493

received training and direction on how to submit an alleged report of abuse to the state agency. An in-service training by a trained consultant was conducted for staff on Vulnerable Adult and Abuse. This education included reviewing the hard copy of the updated Vulnerable Adult Abuse and Prevention Plan, an in-depth discussion on different types of abuse including examples of physical, verbal, and emotional abuse. The staff were also educated on the new disciplinary procedures during reports of alleged abuse. The new Abuse Protocol folders were also reviewed and the contents of them were discussed at the inservice. The director of nursing conducted 2 staff meetings to review Vulnerable Adult policy and procedures. Policy and Procedures of Morning Standup, Weekly IDT, and Quality Assurance were reviewed and revised to include added communication and review of incidents and Vulnerable Adult trends. Grievances and or incidents will be reviewed on a daily basis during the Morning Standup Meeting and weekly with the IDT team which is led by the facility administrator. All unresolved grievances will be reviewed quarterly with the QA team for further review and direction for resolution. An incident log was developed and put into place by the Director of Nursing. All incidents will be reviewed during Morning Standup and then the incident will be placed on the log record. The log will be reviewed weekly during IDT and quarterly with QA to assure that all incidents are fully investigated and complete. A new

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 493	Continued From page 104	F 493	grievance form was developed and put onto place. Staff were educated by the director of nursing on the location and proper use of the new facility grievance forms. Staff education of Vulnerable Adult Policy and Procedure will continue through QAPI. During resident council on 12/18/14, a review of Vulnerable Adult Policy and Procedure and grievance procedure took place. All IDT weekly log minutes will be reviewed quarterly with the QA team to review incidents and potential trends of abuse. Upon this review system revisions and/or staff education will be implemented indicated via proscribed written action plan. New employee hire packets and education were updated to include revisions to Vulnerable adult policy and procedures. Quarterly resident interviews will be conducted by social services or her delegate to facilitate the identification of any actual or potential issues. Quarterly QA meeting occurred on 12/16/14. New changes related to the Vulnerable Adult Policy and Procedure were reviewed with the medical director. Board meeting was held on 12/4/14 and a review of recent state survey was completed. All board members were educated on Vulnerable Adult Policy and Procedures. Board President attended quarterly QA meeting on 12/16/14. Moving forward, one member of the board will attend QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 493	Continued From page 105	F 493	meetings for the next year. A member of the IDT team will attend monthly board meetings. The Governing Board has been invited to attend the Governing Board Leadership Intensive workshop at the annual Leading Age Institute in February. At least one member of the board will attend this workshop. Corrective action for this tag has been completed on 12/18/14.	
F 501 SS=F	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility medical director failed to provide guidance and collaboration with the facility staff related to development, implementation, and evaluation of abuse prohibition policies and procedures in the facility. This deficient practice had the potential to affect all 36 residents currently residing in the facility. Findings include:	F 501	F501 It is the policy of Community Memorial Home to designate a physician to serve as medical director. The medical director is responsible for the implementation of resident care policies; and the coordination of medical care in the facility. In response to F224, F225 and F226: Vulnerable adult reports were filed to the state agency on residents #47 and #12 on 11/19/14 and reports filed on residents	12/18/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

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COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 501

Continued From page 106

Refer to F224, as the facility 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 currently residing in the facility.

Refer to F226, as 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

F 501

#52, 58, and 44 on 11/21/14. All reports were thoroughly investigated and the results of those investigations were filed 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 further training on resident transfers and one employee required additional dementia education. The two employees that received further education were allowed to return to work after the education had been completed. All above residents affected had care plans reviewed. No adjustments were required.
Mood/behavior focus charting was initiated and completed on all residents #52, 58, 44, 47 and 12 to monitor for any changes in psychosocial wellbeing. No concerns or effects from the filed reports were noted.

Interviews conducted with all nursing staff on 11/19/14 and interviews conducted with all residents in the facility on 11/20/14 to identify other potential cases of resident neglect or mistreatment. During resident interviews, one incident was reported. Incident was immediately reported to state agency. The incident was then investigated per Vulnerable Adult Policy and procedures. Staff member involved was suspended and received additional training on transfers prior to her return to work schedule. Safety Risk assessments were completed on all residents and care plan changes were adjusted.

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	245465	A. BUILDING ______ B. WING ______	11/24/2014

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COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 501

Continued From page 107

when an investigation was taking place of potential mistreatment. This had the potential to affect all 36 residents currently residing in the facility.

During interview on 11/24/2014, at 11:03 a.m. the facility medical director (MD) stated he was aware of the concerns of previous abuse situations identified in the facility during the last survey in April 2014, and had spoken with the director of nursing (DON) earlier this week about the current concerns of lack of investigation of alleged incidents of staff mistreatment to residents and failure to report incidents to the state agency and administrator. The MD indicated he was not very involved in developing the plan of correction for the previous survey, and had not done any specific education with the facility staff related to abuse. The MD stated he was typically in the facility on a quarterly basis for the quality assurance meeting and did not come in between meetings unless he had a resident in the facility he needed to see, and currently MD had no patients he was the primary doctor for in the facility. MD stated he reviewed resident incident reports, but could not recall if he had seen an unusual decrease in incidents being forwarded for his review.

The undated facility Medical Director Job Description indicated the MD should assist the DON with resolution of any identified survey issues, and would provide oversight to the medical care provided throughout the care center to ensure the highest medical standards are met at all times. Additionally, the policy indicated the medical director was the keep updated on rules and regulations affecting skilled nursing care and services and ensure medical staff are educated.

F 501

Zero Tolerance statement initiated by facility administrator. Vulnerable Adult Policy and Procedure was reviewed and revised to include the protection of residents during an alleged act of abuse/neglect. Changes include immediate removal and/or suspension of alleged perpetrator. All licensed staff received training and direction on how to submit an alleged report of abuse to the state agency. An in-service training by a trained consultant was conducted for staff on Vulnerable Adult and Abuse. This education included reviewing the hard copy of the updated Vulnerable Adult Abuse and Prevention Plan, an in-depth discussion on different types of abuse including examples of physical, verbal, and emotional abuse. The staff were also educated on the new disciplinary procedures during reports of alleged abuse. The new Abuse Protocol folders were also reviewed and the contents of them were discussed at the inservice. The director of nursing conducted 2 staff meetings to review Vulnerable Adult policy and procedures. Policy and Procedures of Morning Standup, Weekly IDT, and Quality Assurance were reviewed and revised to include added communication and review of incidents and Vulnerable Adult trends. Grievances and or incidents will be reviewed on a daily basis during the Morning Standup Meeting and weekly with the IDT team which is led by the facility administrator. All unresolved grievances will be reviewed quarterly with the QA team for further review and direction for resolution. An incident log

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 501	Continued From page 108	F 501	was developed and put into place by the Director of Nursing. All incidents will be reviewed during Morning Standup and then the incident will be placed on the log record. The log will be reviewed weekly during IDT and quarterly with QA to assure that all incidents are fully investigated and complete. A new grievance form was developed and put onto place. Staff were educated by the director of nursing on the location and proper use of the new facility grievance forms. Staff education of Vulnerable Adult Policy and Procedure will continue through QAPI. During resident council on 12/18/14, a review of Vulnerable Adult Policy and Procedure and grievance procedure took place. All IDT weekly log minutes will be reviewed quarterly with the QA team to review incidents and potential trends of abuse. Upon this review system revisions and/or staff education will be implemented indicated via proscribed written action plan. New employee hire packets and education were updated to include revisions to Vulnerable adult policy and procedures. Quarterly resident interviews will be conducted by social services or her delegate to facilitate the identification of any actual or potential issues. Quarterly QA meeting occurred on 12/16/14. New changes related to the Vulnerable Adult Policy and Procedure were reviewed with the medical director. The Job Description and Policy for the Medical Director was reviewed and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 501	Continued From page 109	F 501	updated. The medical director reviewed all recent policy changes in all department areas during QA meeting on 12/16/14. The Medical Directors Participation in reviewing and acknowledgement of policy compliance will be ongoing. A schedule for policy review has been created with said policies being reviewed prior to QA and discussed and accepted at QA if appropriate. This procedure will be ongoing. The Director of Nursing will be responsible for upkeep of the schedule and distribution of the policies for review. The Administrator will be responsible for compliance. Corrective action for this tag was completed on 12/18/14.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514		12/18/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 110	F 514		

services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to maintain complete and accurate records for 1 of 1 residents (R21) reviewed for pressure ulcers and weight loss.
Findings include:

R21's record included a Wound Assessment/Monitoring form dated 10/20/14, which identified the presence of two left heel pressure ulcers. The wound appearance description identified, "Red discolored skin 4x4 c [with] a dark purple filled blister inside the reddened ring. Skin around site blanches." The wounds were noted to be stage one.

The Wound Assessment/Monitoring form included the following definitions instructing staff on how to stage pressure ulcers:
· A stage one pressure ulcer description included, "Intact skin with non-blanchable redness of a localized area usually over a bony prominence."
· A stage two pressure ulcer description included, "May also present as an intact or open/ruptured serum-filled blister."
· A suspected deep tissue injury was described as a, "Purple or maroon localized are of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or sheer."
· An Unstageable pressure ulcer was,"Full thickness tissue loss with exposed bone, tendon

F514

Comprehensive Skin Assessment and Nutrition Risk Assessment were completed on R21 and added interventions were placed in care plan for weight loss and skin integrity. A correction note was placed in resident record to accurately stage the pressure ulcer.

There are no other residents residing in facility with pressure ulcers. All residents with known skin issues had a review of recent wound assessments to assure that the records were accurately documented.

Wound Policy and Procedure was revised and reviewed with the quarterly QA team. Education was provided to all licensed staff related to the importance of accurate documentation.

Wound documentation will be audited weekly through wound rounds by the DON. The DON will stage all wounds until all licensed staff have received appropriate education and wound staging instructions. The results will be reviewed weekly with IDT and quarterly with QA team.

The corrective action for this tag was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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F 514	Continued From page 111 or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling." R21's Wound/Assessment Monitoring form dated 10/27/14, noted the two pressure ulcers on the left heel with a description which read, "Red discolored skin is 2x2 cm [centimeters] with dark purple filled blister inside reddened ring." The pressure ulcers were documented as a stage one. R21's Wound/Assessment Monitoring form dated 11/3/14, noted the two pressure ulcers on the left heel with a description which read, "Red discolored skin continues with dark filled blister intact." The pressure ulcers were again documented as a stage one. R21's Wound/Assessment Monitoring form dated 11/6/14, noted the two pressure ulcers on the left heel with a description which read, "Red discolored skin continues with dark filled blister intact." The documentation did not include any stage of the pressure ulcers. R21's Wound/Assessment Monitoring form dated 11/11/14, noted the two pressure ulcers on the left heel with a description which read, "Red discolored skin continues with dark filled blister intact." The pressure ulcers were not staged. R21's Wound/Assessment Monitoring form dated 11/14/14, noted the two pressure ulcers on the left heel with a description which read, "Red discolored skin continues with dark filled blister intact." The pressure ulcers were documented as "Unstageable." R21's Wound/Assessment Monitoring form dated 11/17/14, noted the two pressure ulcers on the left heel with a description which read, "Red discolored skin continues with dark filled blister intact." The pressure ulcers were documented as	F 514	completed on 12/18/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 112 "Unstageable." During interview on 11/20/14, at 9:26 a.m. registered nurse (RN)-D stated the RNs were 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.	F 514		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the	F 520		12/18/14

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F 520	Continued From page 113 facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility quality assurance committee failed to identify and develop a plan of action to address concerns related to development, implementation, and evaluation of abuse prohibition policies and procedures in the facility. This deficient practice had the potential to affect all 36 residents currently residing in the facility. Findings include: 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	F 520	F520 It is the policy of Community Memorial Home to maintain a quality assessment and assurance commit-tee consisting of the director of nursing services, a physician designated by the facility; and at least 3 other members of the facility s staff. In response to F224, F225 and F226: Vulnerable adult reports were filed to the state agency on residents #47 and #12 on 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 filed to the state agency within the regulation requirements of the 5 working	

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	245465	A. BUILDING ______ B. WING ______	11/24/2014

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COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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F 520	Continued From page 114 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 currently residing in the facility. Refer to F226, as 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 when an investigation was taking place of potential mistreatment. This had the potential to affect all 36 residents currently residing in the facility.	F 520	days. Internal facility investigation led to the termination of 2 employees. One employee was suspended pending further training on resident transfers and one employee required additional dementia education. The two em-ployees that received further education were allowed to return to work after the education had been completed. All above residents affected had care plans reviewed. No adjustments were required. Mood/behavior focus charting was initiated and completed on all residents #52, 58, 44, 47 and 12 to monitor for any changes in psychosocial wellbeing. No concerns or effects from the filed reports were noted. Interviews conducted with all nursing staff on 11/19/14 and interviews conducted with all residents in the facility on 11/20/14 to identify other potential cases of resident neglect or mistreatment. During resident interviews, one incident was reported. Incident was immediately reported to state agency. The incident was then investigated per Vulnerable Adult Policy and procedures. Staff member involved was suspended and received additional training on transfers prior to her return to work schedule. Safety Risk assessments were completed on all residents and care plan changes were adjusted. Zero Tolerance statement initiated by facility administrator. Vulnerable Adult Policy and Procedure was reviewed and revised to include the protection of residents during an alleged act of	

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	245465	A. BUILDING ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 115 During interview on 11/21/14, at 12:08 p.m. registered nurse (RN)-A stated she thought there was a quality assurance (QA) committee, but was unaware of any current QA projects. During interview on 11/21/14, at 12:17 p.m. RN-C stated she was aware of a QA committee in the facility but was not aware of any current QA projects or concerns they were working on. During interview on 11/21/14, at 12:22 p.m. licensed practical nurse (LPN)-A stated she was not sure if the facility had a QA committee. During interview on 11/21/14, at 1:47 p.m. the administrator stated the facility had been focused on injuries of unknown origin and assisting staff to recognize bruising injuries and how to prevent them. Reporting and recognition of other types of potential abuse had not been a specific focus of the QA committee. The administrator stated all department directors were members of the QA committee to ensure all needs of the facility were covered. The facility policy titled Quality Assurance Plan dated 11/17/08, indicated the objectives of the QA committee included maintaining or improving the physical, psychological, and social well-being of the residents, and the QA committee was to assist departments to continuously improve resident services and care by identifying opportunities through the use of internal monitoring and evaluation activities.	F 520	abuse/neglect. Changes include immediate removal and/or suspension of alleged perpetrator. All licensed staff received training and direction on how to submit an alleged report of abuse to the state agency. An in-service training by a trained consultant was conducted for staff on Vulnerable Adult and Abuse. This education included reviewing the hard copy of the updated Vulnerable Adult Abuse and Prevention Plan, an in-depth discussion on different types of abuse including examples of physical, verbal, and emotional abuse. The staff were also educated on the new disciplinary procedures during reports of alleged abuse. The new Abuse Protocol folders were also reviewed and the contents of them were discussed at the inservice. The director of nursing conducted 2 staff meetings to review Vulnerable Adult policy and procedures. Policy and Procedures of Morning Standup, Weekly IDT, and Quality Assurance were reviewed and revised to include added communication and review of incidents and Vulnerable Adult trends. Grievances and or incidents will be reviewed on a daily basis during the Morning Standup Meeting and weekly with the IDT team which is led by the facility administrator. All unresolved grievances will be reviewed quarterly with the QA team for further review and direction for resolution. An incident log was developed and put into place by the Director of Nursing. All incidents will be reviewed during Morning Standup and then the incident will be placed on the log record. The log will be reviewed weekly	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET** **OSAKIS, MN 56360**

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F 520	Continued From page 116	F 520	during IDT and quarterly with QA to assure that all incidents are fully investigated and complete. A new grievance form was developed and put onto place. Staff were educated by the director of nursing on the location and proper use of the new facility grievance forms. Staff education of Vulnerable Adult Policy and Procedure will continue through QAPI. During resident council on 12/18/14, a review of Vulnerable Adult Policy and Procedure and grievance procedure took place. All IDT weekly log minutes will be reviewed quarterly with the QA team to review incidents and potential trends of abuse. Upon this review system revisions and/or staff education will be implemented indicated via proscribed written action plan. New employee hire packets and education were updated to include revisions to Vulnerable adult policy and procedures. Quarterly resident interviews will be conducted by social services or her delegate to facilitate the identification of any actual or potential issues. Quarterly QA meeting occurred on 12/16/14. New changes related to the Vulnerable Adult Policy and Procedure were reviewed with the medical director. -Quality Assurance Policy and Procedure was reviewed and revised. -All staff were educated on the role of the QA Committee. -Infection control, Vulnerable Adult, and Emergency Policy and Procedures will be reviewed annually by the QA team.	

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	245465	A. BUILDING ______ B. WING ______	11/24/2014

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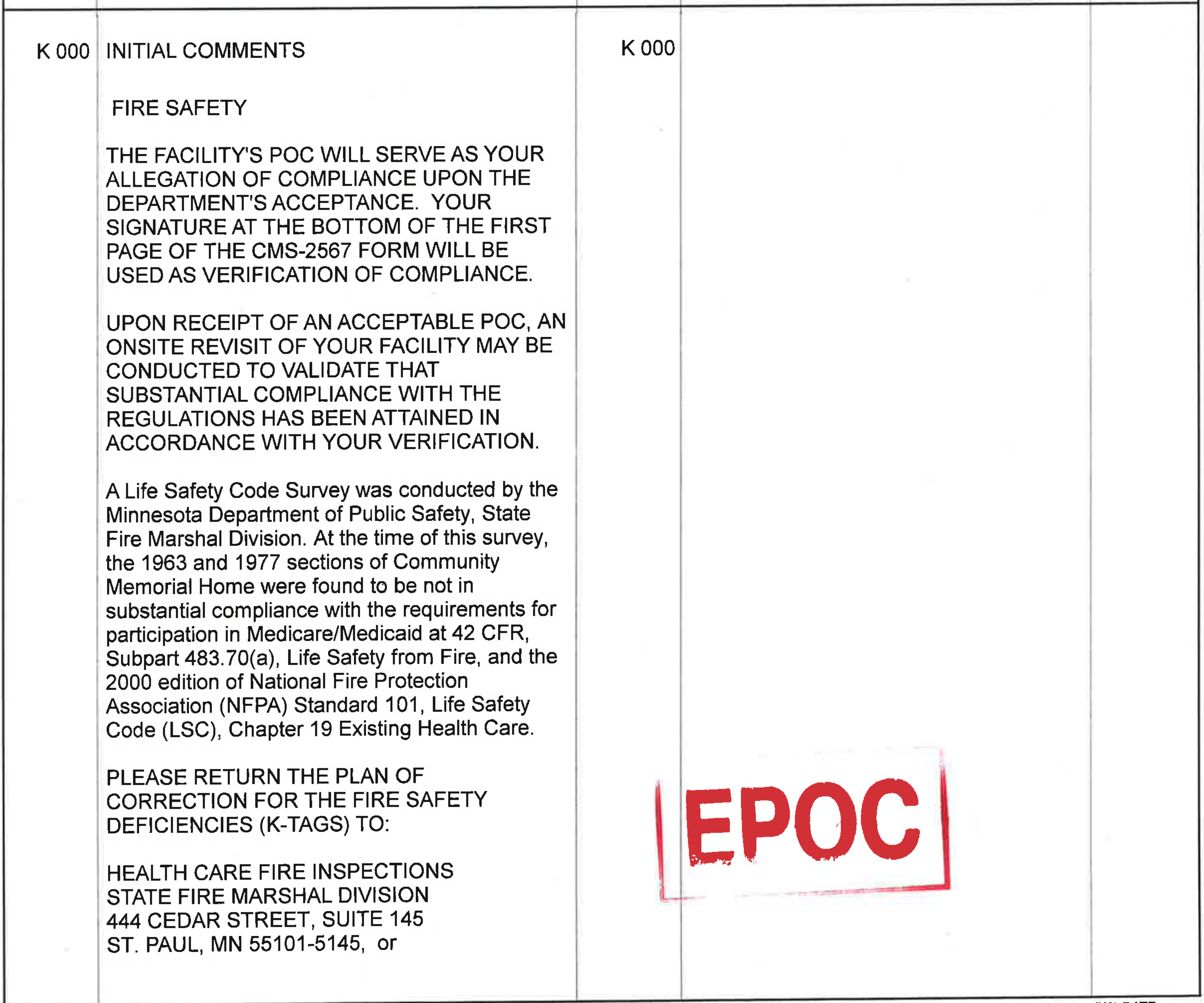
F 520	Continued From page 117	F 520	-A Board member will attend quarterly QA meetings for the next year. The corrective action for this tag was completed on 12/18/14	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____________	**11/19/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET** **OSAKIS, MN 56360**



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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, the 1963 and 1977 sections of Community Memorial Home were found to be not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

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

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	245465	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	11/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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K 000	Continued From page 1 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. 2. 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.	K 000		

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	245465	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**11/19/2014**

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COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET** **OSAKIS, MN 56360**

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and an interview, it was 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	K 067	We are again requesting an annual waiver for K 067.	12/18/14

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	245465	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**11/19/2014**

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K 067	Continued From page 3 plenum. This was confirmed by the Director of Environmental Services (TM) An annual waiver has been previously granted.	K 067		

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 | **2000 CODE**

Community Memorial Home at Osakis, MN Inc.

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item 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 provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067 Heating, Ventilation and Air Conditioning (HVAC) equipment at CMH does not comply with LSC (00) Section 9.2 and NFPA 90A, 1999 Edition because the corridors are used as a plenum.	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: 1. Estimates (5-14-14 attached) that were confirmed on 12-04-14 (attached) show that compliance with NFPA 90A will cost between $446,120 and $579,299. Funding is not available under current reimbursement rules; 2. The electrical system at CMH would need to be modified at a cost that may exceed $42,000; 3. Asbestos abatement required during installation would cost between $59,483 and 81,900; and 4. Non-complying systems are allowed to be used under LSC(00), 9.2.1. B. If this waiver is approved, the safety of building occupants will not be compromised because: 1. CMH was built under Type II construction standards; 2. Walls, floors, ceilings and vertical openings at CMH already resist the passage of smoke; 3. CMH is completely protected by a supervised sprinkler system installed in accordance with NFPA 13; 4. HVAC ventilation fans automatically shut down upon fire alarm activation or the detection of smoke; 5. Resident sleeping rooms are all equipped with single station battery operated smoke detectors; 6. The property of CMH is smoke and tobacco free with signs posted to that effect; 7. All CMH corridors are equipped with a compliant UL listed smoke detection system; 8. The local fire department is located 6 blocks away and will respond to an alarm in less than 10 mins; 9. CMH has an approved fire safety plan and is compliant with all other fire safety requirements; and 10. A continuing waiver has been approved annually in the past for Community Memorial Home. Requested by: *David E. Carlson, Admin 12-18-2014* David E. Carlson, Administrator 12-18-2014

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* [signature]	Title Fire Safety Supervisor	Office State Fire Marshal	Date 12-29-14

3315 Roosevelt Road • Suite 100
St. Cloud, MN 56301

Bus 320.251.0262
Fax 320.251.5749

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

"right from the start"

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. DOLLARS		High Range 24,000 S.F. DOLLARS	
I. LAND				
SUBTOTAL LAND	$ -		$ -	
II. CONSTRUCTION COSTS				
GENERAL CONDITIONS	$ 26,523	$ 1.11	$ 32,448	$ 1.35
INTERIOR FINISHES / DEMO	$ 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	$ 37,132	$ 1.55	$ 43,264	$ 1.80
CONTINGENCY	$ 30,000	$ 1.25	$ 38,000	$ 1.58
SUBTOTAL CONSTRUCTION COSTS	$ 321,748	$ 13.41	$ 413,315	$ 17.22
III. SOFT COSTS				
FEES / PERMITS / PRINTING	$ 64,890	$ 2.70	$ 84,084	$ 3.50
OTHER	$ -	$ -	$ -	$ -
SUBTOTAL SOFT COSTS	$ 64,890	$ 2.70	$ 84,084	$ 3.50
IV. OWNER ITEMS				
FURNITURE/FIXTURES/EQUIPMENT	$ -		$ -	
OTHER - ASBESTOS ABATEMENT	$ 59,483	$ 2.48	$ 81,900	$ 3.41
SUBTOTAL OWNER ITEMS COSTS	$ 59,483	$ 2.48	$ 81,900	$ 3.41
V. TOTAL PROJECT COST	$ 446,120	$ 18.59	$ 579,299	$ 24.14

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

F5465025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245465	(X2) MULTIPLE CONSTRUCTION A. BUILDING **02** B. WING	(X3) DATE SURVEY COMPLETED **11/19/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. 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.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 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.

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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

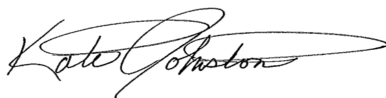
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

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	A. BUILDING: ________ B. WING ________	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On November 17, 18, 19, 20, 21, 22, 23 and 24th 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility quality assurance committee failed to identify and develop a plan of action to address concerns related to development, implementation, and evaluation of abuse prohibition policies and procedures in the facility. This deficient practice had the potential to affect all 36 residents currently residing in the facility. Findings include:	2 255	Corrected	12/20/14

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2 255	Continued From page 3 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 currently residing in the facility. Refer to F226, as 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 when an investigation was taking place of	2 255		

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2 255	Continued From page 4	2 255		

potential mistreatment. This had the potential to affect all 36 residents currently residing in the facility.

During interview on 11/21/14, at 12:08 p.m. registered nurse (RN)-A stated she thought there was a quality assurance (QA) committee, but was unaware of any current QA projects.
During interview on 11/21/14, at 12:17 p.m. RN-C stated she was aware of a QA committee in the facility but was not aware of any current QA projects or concerns they were working on.
During interview on 11/21/14, at 12:22 p.m. licensed practical nurse (LPN)-A stated she was not sure if the facility had a QA committee.
During interview on 11/21/14, at 1:47 p.m. the administrator stated the facility had been focused on injuries of unknown origin and assisting staff to recognize bruising injuries and how to prevent them. Reporting and recognition of other types of potential abuse had not been a specific focus of the QA committee. The administrator stated all department directors were members of the QA committee to ensure all needs of the facility were covered.
The facility policy titled Quality Assurance Plan dated 11/17/08, indicated the objectives of the QA committee included maintaining or improving the physical, psychological, and social well-being of the residents, and the QA committee was to assist departments to continuously improve resident services and care by identifying opportunities through the use of internal monitoring and evaluation activities.

Suggested Method of Correction: The administrator could work with the DON or designee, medical director, and governing body to

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COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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2 255	Continued From page 5 update polices and procedures, identify issues and develop improvement plans. The administrator and or designee could audit cares to ensure resident needs are met, and allegations of resident mistreatment are reported to the state agency and investigated. Time Period for Correction: Fourteen (14) days.	2 255		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to revise the plan of care for 1 of 3 residents (R21) with significant weight loss. Findings include: R21's admission Minimum Data Set (MDS) dated 9/20/14, identified R21 was severely cognitively impaired and was totally dependent on staff for eating. R21's care plan dated 11/17/14, identified R21	2 570	Corrected	12/20/14

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2 570	Continued From page 6	2 570		

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. The care plan did not identify R21 had sustained any weight loss.

R21's nutritional risk assessment completed 9/23/14, identified R21's weight was 159 pounds, received a regular, pureed texture diet, was unable to make meal/food preferences known, was totally fed by staff, and did not make any attempt to feed himself. .

R21's documented weights included the following:
· 9/17/14 159 pounds
· 10/1/14 156.5 pounds
· 10/8/14 156 pounds
· 10/15/14 151.5 pounds
· 10/22/14 149.5 pounds which was flagged as a 6% decrease from 159 pounds less than a month prior
· 10/29/14 148.5 pounds which was a loss of 10.5 pounds since admission
· 11/12/14 148 pounds
· 11/19/14 146 pounds which flagged as 8.2% weight loss from 159 or 13 pounds three months earlier

During interview on 11/20/14, at 9:14 a.m. dietary manager (DM)-A stated the computer system would trigger a notification for her when a resident's weight dropped 5% or greater. DM-A stated R21 had first triggered for weight loss on 10/22/14, with a loss of 6%. DM-A stated she would complete the nutritional part of a resident's care plan, and confirmed as of 11/17/14, R21's care plan had not been updated to reflect nutritional status related to the weight loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 570	Continued From page 7 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 review the care plan for pertinent information. A facility policy titled Care Conferences and Careplan Process last updated on 1/20/10, indicated information for the care plan may come from all disciplines and will be written and updated for each department by staff members trained to write care plans. Care plans would be reviewed monthly, quarterly, and as needed. Suggested Method of Correction: The DON or desigee could work with the interdisciplinary team, MDS coordinator, and nurse managers to review the assessments for accuracy, create comprehensive care plans, review and revise the procedure for care plan updating, and then educate staff. The DON or designee could also perform audits of resident records to determine if care plans were based on comprehensive assessment, updated in a timely fashion, and accessible for staff. Time Period for Correction: Fourteen (14) days.	2 570		
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of	2 625		12/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 625	Continued From page 8	2 625		

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;
F. significant observations on, for example, 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 comprehensive assessments as described in

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2 625	Continued From page 9 part 4658.0400. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to maintain complete and accurate records for 1 of 1 residents (R21) reviewed for pressure ulcers and weight loss. Findings include: R21's record included a Wound Assessment/Monitoring form dated 10/20/14, which identified the presence of two left heel pressure ulcers. The wound appearance description identified, "Red discolored skin 4x4 c [with] a dark purple filled blister inside the reddened ring. Skin around site blanches." The wounds were noted to be stage one. The Wound Assessment/Monitoring form included the following definitions instructing staff on how to stage pressure ulcers: · A stage one pressure ulcer description included, "Intact skin with non-blanchable redness of a localized area usually over a bony prominence." · A stage two pressure ulcer description included, "May also present as an intact or open/ruptured serum-filled blister." · A suspected deep tissue injury was described as a, "Purple or maroon localized are of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or sheer." · An Unstageable pressure ulcer was,"Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include	2 625	Corrected	

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2 625	Continued From page 10	2 625		

undermining and tunneling."

R21's Wound/Assessment Monitoring form dated 10/27/14, noted the two pressure ulcers on the left heel with a description which read, "Red discolored skin is 2x2 cm [centimeters] with dark purple filled blister inside reddened ring." The pressure ulcers were documented as a stage one.
R21's Wound/Assessment Monitoring form dated 11/3/14, noted the two pressure ulcers on the left heel with a description which read, "Red discolored skin continues with dark filled blister intact." The pressure ulcers were again documented as a stage one.
R21's Wound/Assessment Monitoring form dated 11/6/14, noted the two pressure ulcers on the left heel with a description which read, "Red discolored skin continues with dark filled blister intact." The documentation did not include any stage of the pressure ulcers.
R21's Wound/Assessment Monitoring form dated 11/11/14, noted the two pressure ulcers on the left heel with a description which read, "Red discolored skin continues with dark filled blister intact." The pressure ulcers were not staged.
R21's Wound/Assessment Monitoring form dated 11/14/14, noted the two pressure ulcers on the left heel with a description which read, "Red discolored skin continues with dark filled blister intact." The pressure ulcers were documented as "Unstageable."
R21's Wound/Assessment Monitoring form dated 11/17/14, noted the two pressure ulcers on the left heel with a description which read, "Red discolored skin continues with dark filled blister intact." The pressure ulcers were documented as "Unstageable."
During interview on 11/20/14, at 9:26 a.m. registered nurse (RN)-D stated the RNs were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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	Continued From page 11	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

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2 830	Continued From page 12	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. 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. 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. R1's care plan dated 11/21/14, identified R1 used a full BRODA (a type of reclining wheelchair) for locomotion and seating. During observation on 11/17/14, at 6:34 p.m. R1	2 830	Corrected	12/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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2 830	Continued From page 13	2 830		

Continued From page 13

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.

During observation on 11/18/2014, at 2:35 p.m. R1 was again observed with her feet dangling down on her wheelchair footrest with no foot support, and wheelchair cushion remained behind her feet. R1 was continuously observed until 3:27 p.m. when nursing assistant (NA)-A laid R1 down in bed. R1's feet remained dangling above the foot rest with no support 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.

During further 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. the occupational therapist (OT) stated she disliked the BRODA chairs for residents. OT stated R1 had been put in her current chair due to gaining weight and needing a larger chair, and the facility lacked another type of reclining wheelchair which would fit R1. OT was not involved in determining if R1's current wheelchair was appropriate for the resident . OT stated she reported concerns of lack of wheelchair equipment for all residents to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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2 830	Continued From page 14	2 830		

management as recently as the previous week, however, the facility's funding for wheelchair equipment was limited.

R10's quarterly MDS dated 9/25/14, indicated the 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
2 830	Continued From page 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.

During observation on 11/19/14, at 7:51 a.m. R50 was observed seated in the BRODA chair in the dining room. The BRODA chair was in the upright position, and R50's feet were dangling above the floor and did not touch the floor.

During interview on 11/20/14, at 2:08 p.m. the occupational therapist (OT) stated R50 had been put in the BRODA chair due to a diagnoses of kyphosis (a condition that causes excessive curvature of the spine). OT stated R50's wheelchair positioning was, "Not very good," and stated the residents feet should touch the floor so he could propel himself.

R47's quarterly MDS dated 8/7/14, indicated the resident had severe cognitive impairment and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ___ B. WING ___	(X3) DATE SURVEY COMPLETED 11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
2 830	Continued From page 16 required extensive staff assistance to and from destinations with a wheelchair. R47's care plan dated 11/21/14, indicated R47 used a wheelchair for all mobility. R47's OT therapy notes dated 11/12/14, indicated R47 had weakness and poor positioning in her tilt in space wheelchair. R7's nursing progress notes identified the following: -11/6/14, at 10:42 a.m. - Recent falls, trend of leaning forward in wheelchair -11/13/14, at 4:04 p.m. - Resident slouched in wheelchair -11/14/14, at 5:37 a.m. - Resident slouched in wheelchair -11/15/14, at 5:49 a.m.- Resident slouched in wheelchair -11/16/14, at 5:59 a.m. - Resident with hunched position in wheelchair, slumped posture 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 and the facility did not have another suitable wheelchair for R47 to try. The OT had reported concerns regarding	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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2 830	Continued From page 17 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 R47 with an appropriate fitting wheelchair. During observation on 11/21/2014, at 9:30 a.m. R47 was observed in a slouched position, sliding down in her wheelchair while trying to propel herself down the hallway. During interview on 11/21/14, at 1:53 p.m. the administrator stated the facility discussed equipment needs, however, he was not aware of any concerns related to lack of appropriate fitting wheelchair equipment for residents. A policy regarding wheelchair positioning was requested but not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop polices and procedures regarding assessing and monitoring approprate positioning. The Director of Nursing or her designee could educate staff on the policies and procedures, and develop a monitoring system to ensure residents receive the appropriate care. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 830		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the	2 920		12/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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2 920	Continued From page 18	2 920		

comprehensive resident assessment, a nursing home must ensure that:
B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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

During observation of the evening meal on 11/17/14, at 6:03 p.m. R25 had a plate of food in front of her, and a variety of liquids. No staff were present at the table to assist R25 to eat, and the plate of food was just set in front of her. At 6:21 p.m., 18 minutes later, nursing assistant (NA)-A sat down and assisted R25 to eat until 6:29 p.m. At 6:29 p.m. NA-A got up from the stool, began writing on a piece of paper, and walked away from R25. At 6:52 p.m., 23 minutes later, TMA-A sat down and assisted R25 to finish her meal, and at 6:59 p.m. R25 was taken out of the dining room. R25's meal lasted 56 minutes, and ate approximately 25% of the meal.

R40's annual MDS dated 10/9/14, identified R40 was severely cognitively impaired and totally dependent on staff with eating.

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	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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2 920	Continued From page 19	2 920		

During observation of the evening meal on 11/17/14, at 6:04 p.m., NA-A got up from feeding R40. At 6:14 p.m., NA-A returned and continued to feed R40 for four minutes, and then left R40 again to feed another resident. Seven minutes later, at 6:25 p.m., TMA-A sat down and fed R40 until 6:48 p.m., and then wheeled her out of the dining room. R40's meal lasted 44 minutes, and R40 ate approximately 90% of the meal..

R46's annual MDS dated 8/21/14, identified R46 was severely cognitively impaired and required extensive assistance with eating.

During observation of the evening meal on 11/17/14, at 6:03 p.m. R46 was observed sitting at the dining room table with a plate of food and liquids in front of her. No staff were present at the table to assist R40 to eat until 49 minutes later, when TMA-A sat down and started to feed R46. R46 was taken out of the dining room at 6:57 p.m. R46's meal was in front of the resident for 49 minutes before receiving assistance to eat, and the resident ate approximately 10% of the meal.

R58's quarterly MDS dated 10/2/14, identified R58 was severely cognitively impaired and required extensive assistance with eating.

During observation of the evening meal on 11/17/14, at 6:03 p.m. R58 was observed sitting at the dining room table with a plate of food and a variety of liquids on the table in front of her. At 6:09 p.m. (6 minutes later) NA-A sat down next to R58 and gave her several bites of food. 3 minutes later, at 6:12 p.m., NA-A wheeled the stool she was sitting on to the other side of the table and began to feed another resident. At 6:41 p.m. (29 minutes later) TMA-A sat down and fed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ____ B. WING ____	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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 21 for staff regarding timely assistance to residents during dining. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 920		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 3 residents with significant weight loss (R21 and R50) were comprehensively assessed to ensure nutritional needs were met. Findings include: R21 sustained significant weight loss and developed multiple pressure ulcers, however no reassessment of R21's nutritional status was completed. R21 was admitted to the facility on 9/15/14, and had an admission Minimum Data Set (MDS)	2 965	Corrected	12/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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2 965	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 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 assessment or interventions.

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 interventions remained unchanged.

On 11/14/14 the Wound Assessment/Monitoring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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2 965	Continued From page 23	2 965		

form noted the left heel wounds to have declined to an untraceable level. The interventions of continuing to float heels while in bed and in wheelchair remained unchanged. Although the facility identified the pressure ulcers had gotten worse indicating they were now unstageable, no interventions were changed, including contacting dietary to ensure appropriate nutrition to encourage healing.

R21's documented weights included the following:
9/17/14 159 pounds
- 10/1/14 156.5 pounds
- 10/8/14 156 pounds
- 10/15/14 151.5 pounds
- 10/22/14 149.5 pounds which was flagged as a 6% decrease from 159 pounds
- 10/29/14 148.5 pounds which was also flagged as a 5.1% decrease from 156.5 pounds
- 11/12/14 148 pounds
- 11/19/14 146 pounds which flagged as 8.2% weight loss from 159 or 13 pounds

During interview on 11/20/14, at 9:14 a.m. dietary manager (DM)-A stated nursing staff would notify her if a resident had developed a pressure ulcer and she would complete the nutritional assessments to ensure the resident had appropriate nutritional interventions in place to promote healing. DM-A stated any resident identified at nutritional high risk would be reviewed by the consulting dietician. DM-A stated the computer system would trigger a notification for her when a resident's weight dropped 5% or greater. DM-A stated R21 had first triggered for weight loss on 10/22/14, with a loss of 6% and she had been notified of the developed stage one pressure ulcers on 10/20/14. DM confirmed although R21 had a weight loss of >5%, and had developed multiple pressure ulcers, no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ________ B. WING ________	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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 24	2 965		

reassessment of R21's nutritional status had been completed, nor had any interventions been put into place nutritionally to prevent further weight loss or aid in wound healing. DM stated, "It got missed."

During interview on 11/20/14, at 9:26 a.m. registered nurse (RN)-D stated no reassessment had been completed of R21's nutritional status after the weight loss or the development of the pressure ulcers. RN-D stated a supplement had just been started on 11/17/14, "After I talked to you on Monday, I realized that I had not started [R21] on a supplement." RN-D was unable to find any documentation in R21's record which indicated the dietician had been consulted regarding R21's weight loss or worsening pressure ulcers. RN-D stated the RN's on the floor were the ones responsible for completing the Wound Assessment/Monitoring forms. Upon review of the 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 they should have been staged at a stage two. In addition, RN-D stated she had not been notified when R21's pressure ulcers had been noted to go from stage one to unstageable.

During interview on 11/20/14, at 10:46 a.m. consulting dietician (D)-A stated she visited the facility monthly or bi-monthly if the census was low. D-A stated she would expect to be notified if a resident had a 5% or greater weight loss, or had developed a pressure ulcer.

During follow up interview on 11/20/14, at 1:41 p.m. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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 been 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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 26	2 965		

indicated the following:

11/18/2014 - 136.0 lbs
11/11/2014 - 136.0 lbs
11/4/2014 - 135.0 lbs
10/28/2014 - 134.5 lbs
10/21/2014 - 137.5 lbs
10/14/2014 - 140.0 lbs
10/7/2014 - 142.5 lbs
9/30/2014 - 145.0 lbs

During observation on 11/19/2014, at 7:51 a.m. 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.

During interview on 11/20/2014, at 10:58 a.m. D-A stated she came to the facility monthly and the nurses maintained a list of which residents were on supplements. D-A stated the nurses would discontinue nutritional supplements for residents if they were eating well because of budget concerns. D-A stated nurses were responsible to flag residents with weight loss for D-A to review, and the D-M monitored the weights. D-A stated she was not made aware of R50's 9 pound weight loss in the past 45 days, and she would look at possible restarting R50's Boost supplement.

During interview on 11/20/14, at 4:29 p.m. RN-B stated R50's nutritional supplement had been discontinued a little over a month ago because the resident had been eating all of his meals, however, RN-B stated R50's nutritional supplement was being restarted today related to his recent weight loss.

During interview on 11/21/14, at 9:08 a.m. the DM stated R50 was taken off the supplement because he had gained weight. She stated R50's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ________ B. WING ________	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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 27	2 965		

Continued From page 27

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.
- Assess the risk of malnutrition. Identify potential causes.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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 28 plan could be devised to ensure each residents' nutritional needs are met to the extent possible. Audits could periodically be completed. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 965		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain the ice machine in a sanitary manner to minimize the possibility of food borne illness. This had the potential to affect all 36 residents currently residing in the facility who recieved ice from the ice machine. Findings include: During initial kitchen tour on 11/17/14, at 12:32 p.m. an ice machine was observed just outside the kitchen, in the facility dining room. Inside the ice machine a green substance was observed covering the components in the top right corner where the ice was made. The green substance covered the water pump, water trough, ice damper, distribution tube, and evaporator. In addition, there were two trickles of the green substance which ran from the components down the back panel and disappeared behind the	21015	Corrected	12/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21015	Continued From page 29	21015		

already made ice sitting in the ice machine. The dietary manager (DM) verified the green substance, and stated the ice machine had just been moved to the dining room from the assisted living building on 11/14/14, so there was not a cleaning schedule set up yet.

During interview on 11/17/14, at 1:29 p.m. Maintenance (M)-A stated the ice machine was moved in the dining room at the facility on 11/14/14. M-A stated when he brought the ice machine to the facility and installed it in the dining room, he rinsed the machine quickly with bleach, but did not take it apart, made no attempts to scrub off the green substance. M-A thought the green substance was a copper build up, but wasn't 100% certain.

During a follow up observation on 11/18/14, at 10:37 a.m. the green substance was still present in the ice machine. Upon inspection and palpation with a clear plastic gloved finger, the green substance turned the finger tip of the glove green, and was able to be removed just by touching it. M-A removed the machine from service to clean.
Review of the Manitowoc (ice machine manufacturer) Installation, Use and Care Manual dated 2/10, indicated recommendations the machine be cleaned and sanitized every six months and must be taken apart for cleaning and sanitizing.
Review of the undated facility's policy titled Production, Storage, and Dispensing of Ice indicated manufacturer's guidelines for cleaning should be used. The policy further indicated all surfaces should be scrubbed with particular attention to door tracks, guides and gaskets.

SUGGESTED METHOD FOR CORRECTION:
The Administrator and the Dietician could review

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
21015	Continued From page 30 and revise the ice machine policy and procedure to assure that the ice machine is cleaned in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager could monitor the cleaning of the ice machine on a periodic basis. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21015		
21230	MN Rule 4658.0700 Subp. 2 B Medical Director; Implement ResCare Policies Subp. 2. Duties. The medical director, in conjunction with the administrator and the director of nursing services, must be responsible for: B. implementation of resident care policies; This MN Requirement is not met as evidenced by: Based on interview and document review, the facility medical director failed to provide guidance and collaboration with the facility staff related to development, implementation, and evaluation of abuse prohibition policies and procedures in the facility. This deficient practice had the potential to affect all 36 residents currently residing in the facility. Findings include: Refer to F224, as the facility 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	21230	Corrected	12/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21230	Continued From page 31	21230		

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 currently residing in the facility.

Refer to F226, as 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 when an investigation was taking place of potential mistreatment. This had the potential to affect all 36 residents currently residing in the facility.

During interview on 11/24/2014, at 11:03 a.m. the facility medical director (MD) stated he was aware

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
21230	Continued From page 32	21230		

of the concerns of previous abuse situations identified in the facility during the last survey in April 2014, and had spoken with the director of nursing (DON) earlier this week about the current concerns of lack of investigation of alleged incidents of staff mistreatment to residents and failure to report incidents to the state agency and administrator. The MD indicated he was not very involved in developing the plan of correction for the previous survey, and had not done any specific education with the facility staff related to abuse. The MD stated he was typically in the facility on a quarterly basis for the quality assurance meeting and did not come in between meetings unless he had a resident in the facility he needed to see, and currently MD had no patients he was the primary doctor for in the facility. MD stated he reviewed resident incident reports, but could not recall if he had seen an unusual decrease in incidents being forwarded for his review.

The undated facility Medical Director Job Description indicated the MD should assist the DON with resolution of any identified survey issues, and would provide oversight to the medical care provided throughout the care center to ensure the highest medical standards are met at all times. Additionally, the policy indicated the medical director was the keep updated on rules and regulations affecting skilled nursing care and services and ensure medical staff are educated.

SUGGESTED METHOD OF CORRECTION:
The facility could ensure collaboration with the medical director regarding facility policies and procedures related to abuse prohibition. The facility could ensure the medical director reviews all incident and grievance reports to ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21230	Continued From page 33 ongoing compliance with abuse reporting, investigation and interim resident protection requirements. The facility medical director could complete training related to regulations pertinent to reporting and investigation of alleged abuse, and educate staff and other medical providers. TIME PERIOD FOR CORRECTION: Fourteen(14) days.	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: R53's quarterly MDS dated 9/18/14, identified the resident required extensive assistance of two staff for personal hygiene and toileting. During observation on 11/19/14, at 8:12 a.m. the hospice nursing assistant (HNA) and nursing assistant (NA)-E were providing personal cares to	21385	Corrected	12/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
21385	Continued From page 34	21385		

R50. HNA emptied R50's urinary catheter bag into a urinal with gloved hands, dumped the urine in the toilet and rinsed the urinal with water, dumping the rinse water into the toilet. HNA then hung the urinal on the garbage can in the bathroom and removed her gloves. Without washing her hands, the HNA returned to the bedside and proceeded to help NA-E roll the resident side to side for peri care. NA-E applied gloves and took an incontinent wipe to cleanse R50's skin during peri-care. NA-E's gloves became visibly soiled with stool when wiping R50. After wiping R50, NA-E removed her gloves and threw them in the garbage. Without washing her hands, NA-E proceeded to hook R50 up in a mechanical lift sling, touching the sling, the resident's shoulders, and the shower chair during the process.

During interview on 11/19/14, at 8:25 a.m. NA-E confirmed she had not washed her hands after removing the soiled gloves and would wash her hands immediately after she left the room. The HNA stated she had, "thought about" removing her gloves after emptying R50's catheter bag of urine, however, had not done this and should have.

R47's quarterly Minimum Data Set (MDS) dated 8/18/14, identified R47 had severe cognitive impairment, required extensive assistance with all activities of daily living (ADL'S), and was incontinent of bowel and bladder,
During observation on 11/19/14, at 8:30 a.m. nursing assistant (NA)-F and NA-B were observed providing personal cares for R47. NA-F and NA-B had gloves on, and assisted R47 to turn on her right side, and NA-F pulled down R47's incontinent product. NA-F stated the incontinent product contained urine and stool,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21385	Continued From page 35 and NA-F used several disposable wipes to clean R47's perineal area, wiping R47 with her gloved left hand and then switched to wipe with the gloved right hand. Without removing the visibly soiled gloves, NA-F opened the top drawer on R47's bedside stand, picked up a tube of ointment, unscrewed the cap of the tube, squeezed ointment from the tube into her right hand, replaced the 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 picked up the tube of ointment from the bed, opened the drawer, put the tube of ointment into the drawer, and pushed the drawer shut. Without removing the gloves, NA-F picked up the package of disposable wipes from the bed, and tossed them onto the bedside stand. NA-F removed the soiled glove on her right hand, and continued to assist to put R47's clean incontinent product on. NA-F then removed the left glove, and continued to assist NA-B to turn and dress R47. R47 was lying on top of a pad used to protect the bed, and although this pad was visibly soiled with stool, NA-F and NA-B pulled R47's pants up, sliding them across the soiled pad. NA-B removed her gloves, and NA-F and NA-B positioned R47 onto a canvas sling used for the transfer lift, touching the sling, the lift, R47's wheelchair and foot pedals, and the privacy curtain. R47 was transferred and positioned into the wheelchair. NA-F brushed R47's hair and put her glasses on. Without washing her hands, NA-F opened the door to R47's room touching the door handle, and then pushed R47 to the dining room in the wheelchair, touching both handles on the wheelchair. NA-F positioned R47 at the table, picked up the clothing protector, placed it on R47, and secured the clothing protector around R47's neck. NA-F walked back to R47's room, pulled the linens up on the bed, touched the pillow,	21385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21385	Continued From page 36	21385		

straightened items on the bedside table, and picked up a bag that contained the soiled linens and a bag that contained the soiled incontinent product, and carried the two bags through the hallway, to a closed door that she opened, and then threw the bags into receptacles. After disposing of the bags, NA-F then used hand sanitizer to clean her hands.
During interview on 11/19/14, at 8:43 a.m. NA-F stated she touched many items with the soiled gloves during R47's cares and did not remove her gloves after providing personal cares. NA-F verified she did not wash her hands after removing her soiled gloves and before touching many items in R47's room, as well as outside of R47's room. NA-F stated she should have changed gloves after providing personal cares, and should have washed her hands after removing the gloves.
During interview on 11/20/14, at 1:50 p.m. registered nurse (RN)-B stated she had identified concerns with pericare and handwashing when the NA were providing care to residents, and she had re-posted the pericare and handwashing policy in the soiled utility room for the NA's to review. RN-B stated she would expect staff to change their gloves and wash their hands after cleaning a resident of bowel movement.

The facility policy titled Handwashing Policy dated 5/10/14, directed staff to wash hands after each contact with a resident, before serving food or helping residents eat, after removing gloves and other personal protective equipment, and after hand contact with blood or other potentially infectious materials.

During observation on 11/20/14, at 11:10 a.m. licensed practical nurse (LPN)-B performed a blood glucose check on R16. LPN-B wiped

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21385	Continued From page 37 R16's finger with an alcohol wipe, punctured the finger with a lancet, placed a sample of blood on the test strip, and wiped the blood from R16's finger with a cotton ball. LPN-B was not wearing gloves during this time. After the results were read, LPN-B brought the glucometer, test strip, cotton ball, and lancet back to the medication/treatment cart, carrying the supplies in the left hand, and unlocked her cart with keys in her right hand. The items were disposed of, the glucometer was placed back in the cart, and LPN-B proceeded to enter data onto her computer on top of the cart without performing any hand hygiene. When interviewed on 11/20/14, at 3:30 p.m. LPN-B stated she would typically return to her cart, discard the soiled items appropriately, and perform hand hygiene prior to touching the computer. LPN-B verified she did not perform hand hygiene after performing R16's blood glucose testing. A facility policy regarding hand hygiene and blood glucose testing was requested but not provided. Suggested Method of Correction: The DON or her designee could review policy and procedures regarding infection control program. The DON or her designee could educate staff on policy and procedures and develop a monitoring system, to ensure compliance with surveillance analysis and trending was completed. Time Period for Correction: Fourteen (14) days.	21385		
21525	MN Rule 4658.1305 A.B.C Pharmacist Service Consultation	21525		12/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
21525	Continued From page 38	21525		

A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who:
A. provides consultation on all aspects of the provision of pharmacy services in the nursing home;
B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and
C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure 2 of 2 residents, (R25, R37) who received a fentanyl patch (a narcotic pain medication) had consistent and accurate administration and destruction plan to ensure the resident was receiving the medication as prescribed, as well to ensure the fentanyl patches were destroyed to prevent possible diversion.

Corrected

Findings include:

R25's quarterly Minimum Data Set (MDS) dated 10/16/14, identified the resident had severe cognitive impairment, was on scheduled pain medication, and had no signs or symptoms of pain.

R25's current physician orders dated 11/17/14, indicated Fentanyl 25 mcg patch every 72 hours for pain. The Fentanyl prescription was started on 2/5/13.

Review of R25's Individual Narcotic Record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	00109		11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21525	Continued From page 39	21525		

indicated a Fentanyl patch was administered on 1/25/14, and the next patch was not administered until 1/30/14, five days later. However, R25's Medication Administration Record (MAR), indicated R25 received a Fentanyl patch on 1/25/14, 1/28/14, and 1/30/14.

During interview on 11/20/14, at 10:15 a.m. registered nurse (RN)-A stated she was unsure why R25's narcotic record and MAR did not match indicating when the resident actually received the Fentanyl patch. RN-A stated there was no medication error report for R25, and stated the Fentanyl patch counts for the facility had not been off.

R37's admission MDS dated 9/15/14, identified the resident had moderate cognitive impairment, was on a scheduled and PRN (as needed) pain medication, and had moderate, frequent pain.

R37's current physician orders dated 11/19/14, indicated Fentanyl 25 mcg patch every 72 hours for pain.

Review of R37's Individual Narcotic Record indicated a Fentanyl patch was administered on 9/14/14, and the next patch was not administered until 9/20/14, six days later. R37 received a Fentanyl patch on 10/9/14, and the next patch was not administered until 10/13/14, four days later. The Fentanyl patches were also not signed off by two nurses when destroyed per facility policy on 9/8/14, 9/26/14, 10/2/14. On 10/13/14, there was only one nurse's signature, and written next to it was, "No patch to remove."

Review of R37's MAR for September 2014, indicated the resident received a Fentanyl patch on 9/14/14, and did not receive the next patch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
21525	Continued From page 40	21525		

until 9/20/14, six days later. R37's MAR for October 2014, indicated R37 received a Fentanyl patch on 10/8/14, 10/9/14, 10/12/14, and again on 10/13/14.

The facility provided two Medication Error forms for R37 which identified the following:

10/12/14- "Fentanyl patch due to be changed on 10/12/14. No patch available to apply... Patches were not reordered when last patch was applied..."
10/19/14- "During AM (morning) cares resident's Fentanyl patch from 10/9/14, was still on resident's left shoulder..."

During interview on 11/20/14, at 10:15 a.m. RN-A stated R37 was to have a Fentanyl patch applied every 72 hours for pain. RN-A was unable to determine why the MAR and Narcotic record didn't match, and stated the nurses needed more training regarding documentation of administration and destruction of the Fentanyl patches. RN-A stated the facility nurses had training several months ago regarding destruction and administration of Fentanyl patches, and they were instructed two nurses must witness and sign off the destruction of Fentanyl patches. RN-A stated the facility did not have a specific Fentanyl patch destruction policy, however, the facility had a policy on destroying all medications with a witness.

During interview on 11/26/14, at 10:00 a.m. consulting pharmacist (CP)- G stated when she goes to the facility, she reviews the current Fentanyl patch count along with the Narcotic Book, to ensure the Fentanyl patch count is correct. CP-G stated with the current documentation system, it is difficult to determine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ____ B. WING ____	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21525	Continued From page 41 when the resident actually received the patch. CP-G stated two nurses should be signing off when a Fentanyl patch is removed from a resident and destroyed, and she plans on doing more education for the facility regarding documentation and destruction of Fentanyl patches. 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 Correction: Fourteen- (14) days.	21525		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan	21530		12/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
21530	Continued From page 42 system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist'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 is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the consultant pharmacist (CP) failed to identify and forward irregularities to the attending physician for 1 of 1 residents (R1) reviewed for unnecessary medication who received multiple psychoactive drugs (medications that have significant effect on mood and behavior) who lacked clear indications for use.	21530	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
21530	Continued From page 43	21530		

Findings include:

R1's quarterly Minimum Data Set (MDS), dated 10/23/14, identified the resident had no cognitive impairment, had a PHQ-9 (a test to determine depression severity) score of 2 (minimal depression), and exhibited no behaviors.

R1's care area assessment (CAA) for psychoactive drug use dated 5/16/14, indicated R1 had a history of psychiatric illness and was prone to crying and anxiety, and Cymbalta [an antidepressant] was helpful.

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 orders, dated 11/21/14, identified current medication orders including:

Abilify (an antipsychotic medication) 10 milligrams (mg) every day at bedtime for dementia/schizophrenia
Buspar (an anxiolytic) 20 mg twice daily for anxiety
Clonazepam (an anxiolytic) 0.5 mg three times daily for anxiety/dementia
Cymbalta (an antidepressant) 60 mg every day for anxiety/depression/peripheral neuropathy
Gabapentin (an anticonvulsant/analgesic) 300 mg by mouth twice daily for dementia/schizophrenia in the morning and evening, and an additional 200 mg daily at 1 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21530	Continued From page 44	21530		

Klonopin (an anxiolytic) 0.5 mg by mouth daily as needed for anxiety
Zoloft (an antidepressant) 75 mg by mouth every day for anxiety/depression

R1's pharmacy consultant reviews for the previous seven months indicated irregularities identified on 10/20/14, with relation to considering a dose reduction for R1's buspirone (an anxiolytic). No other irregularities were listed in relation to R1's multiple psychoactive medications.

Review of R1's behavior monitoring sheets for October- November 2014, indicated two episodes of feeling anxious, and one episode of irritability, both were redirectable with 1:1 visits or distraction.

During observation on 11/17/14, at 2:20 p.m. R1 was observed in bed. R1 had a flat facial affect but was alert and attentive, and displayed no adverse behaviors. She did not express any feelings of emotional distress.

During observation on 11/18/14, at 2:35 p.m. R1 was in the dayroom watching television. She had a flat facial expression, was alert, and displayed no adverse behaviors.

During interview on 11/18/14, at 3:26 p.m. NA-A and NA-D stated R1 did not have a lot of behaviors, only occasional tearfulness.

During interview on 11/20/14, at 11:18 a.m., registered nurse (RN)-C stated R1 did not display any behaviors and was set in her routine.

During interview on 11/20/2014, at 4:11p.m., the consultant pharmacist (CP)-A stated there were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21530	Continued From page 45	21530		

some "legitimate concerns" with the diagnosis or indications for use for R1's multiple psychoactive drugs. CP-A stated the medication indications needed to be more defined as to exactly what condition was being treated as there were multiple diagnoses listed for the medications, and further stated Gabapentin for schizophrenia would "never fly," indicating it was not an appropriate diagnoses. CP-A stated there was another pharmacist that came to the building more often, and he would have that pharmacist return a call.

During interview on 11/20/2014, at 4:16 p.m. RN-B stated R1 was doing well right now with her behaviors and did show some perseveration on a topic and will not let it go. Her behaviors did not disrupt her daily routine.

During interview on 11/21/14, at 10:25 a.m. CP-B, who was the regularly scheduled consultant pharmacist for the facility, stated she monitored R1's medication effectiveness through "trial and error," as there were multiple diagnoses and duplicate medication class therapy for some of the psychoactive drugs.

The facility policy titled Psychotherapeutic Medications dated 3/4/13, indicated a resident will not receive psychotherapeutic medications unless such a medication is needed to treat a specific condition, and each psychotherapeutic medication will be given to treat clearly defined target behaviors. The policy further stated duplicative drug therapy would be closely monitored and discouraged.

A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
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.	21530		
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 is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.	21540		12/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
21540	Continued From page 47	21540		

This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure 1 of 1 residents (R1) who received multiple psychoactive drugs (medications that have significant effect on mood and behavior) had clear indications for use. In addition, the facility failed to ensure 1 of 1 discharged residents (R72) with multiple pain medication orders had appropriate parameters for use.

Corrected

Findings include:

R1's quarterly Minimum Data Set (MDS), dated 10/23/14, identified the resident had no cognitive impairment, had a PHQ-9 (a test to determine depression severity) score of 2 (minimal depression), and exhibited no behaviors.

R1's care area assessment (CAA) for psychoactive drug use dated 5/16/14, indicated R1 had a history of psychiatric illness and was prone to crying and anxiety, and Cymbalta [an antidepressant] was helpful.

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 orders, dated 11/21/14, identified current medication orders including:

Abilify (an antipsychotic medication) 10 milligrams

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
21540	Continued From page 48 (mg) every day at bedtime for dementia/schizophrenia Buspar (an anxiolytic) 20 mg twice daily for anxiety Clonazepam (an anxiolytic) 0.5 mg three times daily for anxiety/dementia Cymbalta (an antidepressant) 60 mg every day for anxiety/depression/peripheral neuropathy Gabapentin (an anticonvulsant/analgesic) 300 mg by mouth twice daily for dementia/schizophrenia in the morning and evening, and an additional 200 mg daily at 1 p.m. Klonopin (an anxiolytic) 0.5 mg by mouth daily as needed for anxiety Zoloft (an antidepressant) 75 mg by mouth every day for anxiety/depression Review of R1's behavior monitoring sheets for October- November 2014, indicated two episodes of feeling anxious, and one episode of irritability, both were redirectable with 1:1 visits or distraction. During observation on 11/17/14, at 2:20 p.m. R1 was observed in bed. R1 had a flat facial affect but was alert and attentive, and displayed no adverse behaviors. She did not express any feelings of emotional distress. During observation on 11/18/14, at 2:35 p.m. R1 was in the dayroom watching television. She had a flat facial expression, was alert, and displayed no adverse behaviors. During interview on 11/18/14, at 3:26 p.m. NA-A and NA-D stated R1 did not have a lot of behaviors, only occasional tearfulness. During interview on 11/20/14, at 11:18 a.m., registered nurse (RN)-C stated R1 did not display	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21540	Continued From page 49	21540		

any behaviors and was set in her routine.

During interview on 11/20/2014, at 4:11p.m., the consultant pharmacist (CP)-A stated there were some "legitimate concerns" with the diagnosis or indications for use for R1's multiple psychoactive drugs. CP-A stated the medication indications needed to be more defined as to exactly what condition was being treated as there were multiple diagnoses listed for the medications, and further stated Gabapentin for schizophrenia would "never fly," indicating it was not an appropriate diagnoses. CP-A stated there was another pharmacist that came to the building more often, and he would have that pharmacist return a call.

During interview on 11/20/2014, at 4:16 p.m. RN-B stated R1 was doing well right now with her behaviors and did show some perseveration on a topic and will not let it go. Her behaviors did not disrupt her daily routine.

During interview on 11/21/14, at 10:25 a.m. CP-B, who was the regularly scheduled consultant pharmacist for the facility, stated she monitored R1's medication effectiveness through "trial and error," as there were multiple diagnoses and duplicate medication class therapy for some of the psychoactive drugs.

The facility policy titled Psychotherapeutic Medications dated 3/4/13, indicated a resident will not receive psychotherapeutic medications unless such a medication is needed to treat a specific condition, and each psychotherapeutic medication will be given to treat clearly defined target behaviors. The policy further stated duplicative drug therapy would be closely monitored and discouraged.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21540	Continued From page 50	21540		

R72's admission progress note dated 11/5/14, indicated the resident was admitted to the facility to recover after fracturing the coccyx. R72's admission minimum data set (MDS) dated 11/11/14, identified R72 had no cognitive impairment, had been receiving PRN (as needed) pain medication, and had frequent pain.

R72's current care plan dated 11/14/14, instructed staff to ask the resident about pain and offer analgesia at least 30 minutes prior to therapy.

R72's Pain Assessment dated 11/4/14, indicated the resident had constant pain at all times, and was using PRN pain medications of Norco 5-325 mg, 1-2 tabs every 4 hours, and Tylenol 1000 mg every 6 hours. The summary of R72's pain assessment was, "...has PRN Norco and Tylenol for pain... Did explain the use of PRN medication to [R72] and staff are to monitor her for non verbal and verbal cues to pain..."

R72's current physician orders dated 11/14/14, indicated R72 was prescribed the following PRN pain medications:

- Norco (Hydrocodone- Acetaminophen) 3-325 mg tablet PRN, 1-2 tablets, every 4 hours for pain.
- Tylenol Extra Strength (Acetaminophen) 1000 mg tablet PRN, Every 6 hours for pain.

R72's physician orders did not include parameters which directed staff when R72 was to receive Tylenol vs Norco, nor did it instruct staff when to administer one or two tablets of Norco.

Review of R72's Medication Administration Record (MAR) for November 2014, indicated from 11/5/14- 11/18/14, R72 received 43 doses of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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21540	Continued From page 51	21540		

Norco. Of the 43 separate administration times, R72 received 2 tablets of Norco 40 times, and 1 tablet of Norco 3 times. On 11/9/14, R72 received Tylenol 1000 mg, as well as two doses of Norco, 2 tablets. On 11/10/14, R72 received Tylenol 1000 mg, as well as two doses of Norco, 2 tablets.

During interview on 11/20/14, at 9:55 a.m. RN-B stated when residents are admitted with medication orders that included ranges, such as taking 1-2 tablets, the nursing staff should call the physician to obtain specific orders to ensure staff know what actual dose of Norco the resident should receive, or else the consulting pharmacist usually will catch it when doing the pharmacy review, however, R72 had not yet had a pharmacy review of medications since admission to the facility. RN-B stated R72's Norco order should have instructed when R72 should receive one Norco or two, as well as when the resident should receive Tylenol vs Norco.

During interview on 11/20/14, at 10:10 a.m. licensed practical nurse (LPN)-B stated when she administered R72 Norco, she usually just gave her 2 tablets because the resident was having significant pain. LPN-B stated when residents have PRN pain medication orders, usually there is an order which instructs staff on how much pain medication to give depending on the residents range of pain, however, R72 did not have specific orders, so the nurses just administered the pain medication according to how the resident was doing on a specific day.

A policy on medication range orders was requested, but not provided.

A SUGGESTED METHOD FOR CORRECTION:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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21540	Continued From page 52 The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents do not receive unnecessary medications, ensure all medications include parameters, and educate all relevant staff. The DON or designee can develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21540		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure resident wheelchairs were clean for 1 of 1 residents (R21) observed with a soiled wheelchair. In addition, the facility failed to ensure wheelchairs were in good repair for 1 of 1 resident (R47) observed with a torn armrest. Findings include: On 11/18/14, at 9:35 a.m. R21's wheelchair was noted to be full of debris and crumbs on the pad of the wheelchair, appeared soiled on the right hand corner. On 11/20/14, at 10:58 a.m. R21 observed sitting	21665	Corrected	12/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21665	Continued From page 53	21665		

in the wheelchair in the activities area. Debris and dust were noted below the seat of the wheelchair.

On 11/20/14, at 1:40 p.m. maintenance (M)-A observed R21's wheelchair and verified there was dirt and debris present. After consulting with housekeeping, a copy of the Wheelchair Washing Log (West) was provided for October, November, and December 2014, which indicated all resident wheelchairs were to be washed twice a month on the cleaning schedule. R21's wheelchair had no documentation of being cleaned / washed during October or November. A copy of the Twice a Month Wheelchair Washing Log (West) was requested and received for May 2014 through September 2014, and the last documented washing of R21's wheelchair was on 9/18/14. M-A verified housekeeping should be cleaning/washing the wheelchairs twice per month per policy, and if they are heavily soiled, they are brought to maintenance to take apart and clean. M-A stated he has not done cleaning on R21's wheelchair.

The undated facility policy titled Wheelchair washing indicated all wheelchairs within the nursing home shall be inspected each shift, wiped down as needed, and washed at least twice a month according to the wheelchair washing schedule.

During observation on 11/20/2014, at 10:30 a.m. R47's wheelchair was observed with a torn left armrest, with exposed foam which created an uncleanable surface.

During observation on 11/21/2014, 9:30 a.m. R47's wheelchair was again observed with exposed foam on the left arm rest which was also

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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21665	Continued From page 54 noted to be frayed. During interview on 11/24/2014, at 12:26 p.m. M-A stated R47's wheelchair needed new armrests and he tried to visually inspect all resident equipment in disrepair which would require repairs, however, there was no maintence schedule of inspection. MA-A stated staff were to notify him if they saw any equipment that needed to be fixed. During interview on 11/21/2014, at 2:03 p.m. the administrator stated the facility maintenance staff monitored for equipment in disrepair and dealt with issues as soon as they became aware of them. He was unaware of any concerns with R47's wheelchair armrest that was torn and uncleanable. The undated facility policy titled Equipment Repair and Maintenance indicated maintenance would conduct monthly equipment checks and repair equipment as needed. SUGGESTED METHOD OF CORRECTION: The maintenance department could include a visual inspection of residents wheelchairs house wide to ensure wheelchairs were in good repair and cleanable. This could be monitored by the DON or designee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21665		
21705	MN Rule 4658.1415 Subp. 6 Plant Housekeeping, Operation, & Maintenance Subp. 6. Heating, air conditioning, and ventilation. A nursing home must operate and	21705		12/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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21705	Continued From page 55 maintain the mechanical systems to provide comfortable and safe temperatures, air changes, and humidity levels. Temperatures in all resident areas must be maintained according to items A to C: A. For construction of a new physical plant, a nursing home must maintain a temperature range of 71 degrees Fahrenheit to 81 degrees Fahrenheit at all times. B. For existing facilities, a nursing home must maintain a minimum temperature of 71 degrees Fahrenheit during the heating season. C. Variations of the temperatures required by items A and B are allowed if the variations are based on documented resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain comfortable room temperatures for 1 of 3 residents (R45) reviewed for complaints of cold room temperatures. Findings include: R45's quarterly Minimum Data set (MDS) dated 10/16/14, indicated R45 had no cognitive impairment. During interview on 11/17/14, at 6:10 p.m. stated his room was too cold. R45 was wearing a long sleeved shirt and was covered with a blanket. The thermostat in R45's room read 68 degrees. During observation of R45's room on 11/20/14, at 9:00 a.m. the thermometer read 66 degrees. R45 was not in his room at this time. During observation of R45's room on 11/20/14, at	21705	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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21705	Continued From page 56	21705		

Continued From page 56

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 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 getting in."

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 adequate.

Time Period for Correction: Fourteen (14) days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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21805	Continued From page 57	21805		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 10 of 13 residents who required staff assistance with eating (R1, R3, R10, R14, R19, R21, R25, R40, R46 and R58) were provided dining assistance in a dignified manner. Findings include: R1's quarterly Minimum Data Set (MDS) dated 9/11/14, identified R1 was severely cognitively impaired and required extensive assistance with eating. R3's annual MDS dated 9/18/14, identified R3 was severely cognitively impaired and required extensive assistance with eating. R10's quarterly MDS dated 9/25/14, identified R10 was severely cognitively impaired and required extensive assistance with eating. R14's annual MDS dated 8/21/14, identified R14 was severely cognitively impaired and required extensive assistance with eating. R19's quarterly MDS dated 8/7/14, identified R19 was severely cognitively impaired and required	21805	Corrected	12/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ____ B. WING ____	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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21805	Continued From page 58	21805		

extensive assistance with eating.

R21's admission MDS dated 9/20/14, identified R21 was severely cognitively impaired and was totally dependent on staff for eating.

R25's quarterly MDS dated 10/16/14, identified R25 was severely cognitively impaired and required extensive assistance with eating.

R40's annual MDS dated 10/9/14, identified R40 was severely cognitively impaired and was totally dependent on staff for eating.

R46's annual MDS dated 8/21/14, identified R46 was severely cognitively impaired and required extensive assistance with eating.

R58's quarterly MDS dated 10/2/14, identified R58 was severely cognitively impaired and required extensive assistance with eating.

During observation of the evening meal on 11/17/14, from 6:04 p.m. to 6:37 p.m., nursing assistant (NA)-A was observed sitting on a round stool which had wheels on. NA-A wheeled around two tables where R25, R46, R40, R14, R58 and R19 sat. NA-A would spend a few minutes feeding one resident, and then would wheel around to another resident either at the same table or another table and feed them for a few minutes, and then roll away to another resident to assist them with eating. NA-A stopped rolling on the stool, stood up, and spoke with R19 twice encouraging the resident to eat. R19 refused to eat. NA-A did not sit down or spend more than a few seconds encouraging R19 to eat. At 6:37 p.m., NA-A started removing residents from the dining room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21805	Continued From page 59	21805		

During the same meal observation from 6:03 p.m. until 6:27 p.m., NA-D was observed alternating between a stool with wheels, and stationary chairs placed around tables while assisting R21, R10, R1 and R3. During the meal NA-D was observed telling R1 she was, "Going to help [R21] now." R1 continued to ask for bites of food and NA-D replied, "I know, we're just going to assist everyone else for a bit. We're not going to forget you." R1 was observed attempting to drink from a straw several different times, but was unable to do so without assistance.

During interview on 11/20/14, at 2:10 p.m. trained medication aid (TMA)-A stated there was usually four staff in the dining room during the evening meal to assist approximately 12 residents who required assistance with eating. TMA-A stated staff usually feed the residents who could eat the fastest first and then move on to the others. TMA-A stated an hour was the typical time it took from the beginning of the meal to the end, when the last person who needed assistance was finished eating.

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 required assistance with eating in the dining room during the evening meal. RN-A stated which the resident who arrived in the dining room first, is who got fed first. RN-A stated she did not think serving all the residents at the same time and then wheeling around every couple of minutes was a dignified dining experience, and felt the residents should not be rushed and mealtime should be home like. RN-A stated should focus on feeding possibly two residents at a time, and residents who are unable to be assisted timely, should have their food held

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21805	Continued From page 60 in the warmer instead of sitting out getting cold while waiting. During interview on 11/20/14, at 5:22 p.m. NA-G recalled being present in the dining room during the meal on 11/17/14. NA-G did not recall observing NA-A or NA-D wheeling around the dining room, but stated it was not a dignified manner of feeding residents. During interview on 11/21/14, at 1:50 p.m. the administrator stated he was aware staff were using stools with wheels on them and working to feed multiple residents at the same time. The administrator stated it was obviously not ideal. 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. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure all residents' dignity is maintained. The DON or designee could educate all appropriate staff on the policies and procedures, and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21805		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act.	21850		12/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21850	Continued From page 61 "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility 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. The immediate jeopardy began on 11/19/14, at 4:19 p.m. when the facility failed to comprehensively assess, investigate, and implement interventions to ensure residents who were involved in alleged incidents of staff mistreatment, were free from staff abuse. On 11/19/14, at 4:19 p.m. the administrator and director of nursing (DON) were notified of the	21850	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
21850	Continued From page 62	21850		

immediate jeopardy (IJ) for all 36 residents currently residing in the facility. The IJ was removed on 11/24/14, at 1:07 p.m. but noncompliance remained at a widespread scope and severity level, with potential for actual harm.

Findings include:

R52's Face Sheet dated 11/20/14, identified diagnoses including hip joint replacement, scoliosis, and pain in the pelvic region and thigh.

R52's quarterly Minimum Data Set (MDS) dated 10/23/14, identified R52 had no cognitive impairment and required extensive weight bearing assistance from two staff for transfers.

During interview on 11/17/14, at 3:34 p.m. R52 stated a few weeks ago, a male nursing assistant (NA) grabbed her on the arm during a transfer from the wheelchair to the bed, and was so rough she hit her hip on the nightstand table. R52 stated she, "Hollered and screamed from the pain," because the transfer was so rough. R52 stated she reported the incident to the registered nurse (RN) case manager, but no one from the facility had spoken to her about the incident.

During another interview on 11/8/14, at 2:53 p.m. R52 again shared her concerns of rough treatment from a staff member during a transfer, and stated she thought the NA was too rough when he assisted her and didn't understand what it was like to be in pain. R52 stated the NA had not provided cares to her since this incident, but she would, "Shy away," from that NA if he were to provide cares to her again due to the pain he caused during the last time he assisted her to transfer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21850	Continued From page 63 During interview on 11/18/14, at 3:35 p.m. DON stated she was aware of R52's allegation of a male NA transferring her roughly, and she had spoken with both R52 and the NA about the incident. The DON confirmed no report had been made to the SA regarding the allegation, The administrator was not notified immediately of the allegation, and there was no documented investigation determining what had happened. During interview on 11/18/14, at 6:29 p.m. social service (SS)-A and the DON were interviewed regarding R52's complaint of rough treatment by the NA. SS-A stated R52's family had called her and reported R52 was upset about rough treatment by staff during a transfer. SS-A stated she had talked to the NA and charge nurse about the incident, however, SS-A stated she had not documented the investigation regarding the findings of the interviews, and she did not report this to the state agency or administrator. SS-A and DON stated they had spoken with R52 about the incident, and the resident did not experience any injury, so they didn't believe the allegation met the definition of potential abuse, neglect, or mistreatment, and determined no report needed to be made to the state agency. SS-A and DON stated there was no documentation regarding any investigation or interviews, and the NA who was accused of rough treatment of R52 had no further training or monitoring to ensure further resident mistreatment did not occur. During interview on 11/18/14, at 3:27 p.m. RN-B stated she was aware R52 had concerns about a month ago regarding being transferred roughly by a NA. RN-B stated interviews had been completed with the NA accused of transferring R52 roughly, as well as with R52, but she had not documented any of the investigation, nor had she	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
21850	Continued From page 64	21850		

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 intentionally mistreat a resident.

R58's quarterly MDS dated 10/2/14, indicated R58 had severely impaired cognition, and required assistance with all ADL's, including eating.
Review of a facility Problem Resolution form dated 8/7/14, indicated R58 was eating in the dining room and NA-D was overheard telling R58, "You have to eat, there is nothing in your mouth so there is no reason why you won't eat!" NA-D 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 8/8/14, by the RN case manager. [NA-D] stopped

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
21850	Continued From page 65	21850		

in DON office on 8/11/14, to apologize for the incident." There was no further investigation of the mistreatment to R58, and it was not reported to the state agency.
During interview on 11/19/14, 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 incident, and it was not reported to the administrator or state agency because they did not believe there was any abuse that took place and R58 had no ongoing effects from the incident.
During interview on 11/19/14, at 2:36 p.m. DON stated when she spoke to NA-D about the incident with R58, NA-D knew how she acted was wrong, and NA-D stated it would not happen again. DON stated NA-D did not receive re-education or corrective action, NA-D was not being monitored to observe her interaction with other residents, there was no further investigation of the incident, and it was not reported to the state agency. DON did not feel this was abuse or mistreatment because R58 was not harmed, and NA-D knew her actions were not acceptable and apologized.
R44's annual MDS dated 10/2/14, indicated the resident had diagnoses including Alzheimer's disease, had moderately impaired cognition, and required assistance of one staff with ADL's, and set up assistance with meals.
The facility provided a untitled document which was kept in the DON's office regarding an incident involving R44 and NA-D. The document indicated on 11/3/14, NA-D brought R44 to the dining room in his wheelchair and the dining room was not open for breakfast yet. The untitled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21850	Continued From page 66 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 sitting in the hallway in his wheelchair and walked away, and RN-C assisted R44 to get a snack. The untitled 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 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 had 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,	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
21850	Continued From page 67	21850		

written by RN-C regarding concerns with NA-D and resident mistreatment, indicated NA-D, "What I felt as demeaning to a resident at noon meal, stating rudely that a resident could feed herself, even though this resident does need more assistance to feed herself." There was no follow up with NA-D regarding RN-C concerns of being rude to the resident. During multiple interviews with staff, no one was able to recall who the resident was NA-D had been rude to.

R47's Admission Record dated 11/11/14, included diagnoses of Alzheimer's disease and urinary incontinence. R47's quarterly MDS dated 8/18/14, identified R47 had severe cognitive impairment, was incontinent of bowel and bladder, required extensive assistance of two staff for bed mobility, and was totally dependent on staff for toileting and personal hygiene. During interview on 11/18/14, at 11:19 a.m. family member (FM)-A stated while visiting R47 about five months ago, she stepped out of R47's room into the hallway while two nursing assistants provided personal cares for R47. FM-A heard R47 moaning, and went into R47's room to check on her. FM-A stated she pulled back the privacy curtain, and witnessed an unidentified NA holding R47 on her side, and the NA was leaning on R47 with her elbow, which FM-A felt was causing R47, "Pain." FM-A stated this made her upset, and she reported the incident to 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
21850	Continued From page 68	21850		

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 another 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 did not feel that they were being rough...It was a one-time thing...There wasn't a lot to it...It 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. This incident was not reportable." SS-A stated she did not report the incident to the administrator, and did not know if it was in their policy that she needed to report the incident to the administrator if it was not considered abuse. SS-A could not recall who the employees were accused of being rough with R47, and stated nothing would be in the employees personal file because it was not determined there was any mistreatment to R47.

During interview on 11/19/14, at 9:00 a.m. DON stated when a complaint is received, the facility should review the incident, "To see if it's reportable...whoever receives the concern follows

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21850	Continued From page 69	21850		

up with the family...You don't want to over report...If 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
21850	Continued From page 70	21850		

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, they had overheard R12 ask NA-J for assistance to use the restroom. NA-J stated to R12, "I told you that when I was done, I would help you. Now be quiet!" The visitor stated she had not told anyone at the facility about this, but stated this had made her uncomfortable as she felt the staff were very rude.

During interview on 11/21/14, at 10:07 a.m. DON stated the reported incident/ grievance of staff mistreatment involving R12, which was documented on the grievance form dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21850		21850		

Continued From page 71

11/12/14, had not been reported to the administrator or the SA. DON had no investigation of the incident, and could not verify if any staff were interviewed or re-educated regarding toileting R12.

During interview on 11/18/14, at 11:45 p.m. RN-B stated if the facility had an accusation of staff mistreatment, it would depend on the severity of allegation to determine the investigation, if it required reporting, and if it would be documented. RN-B stated the facility had incident reports, which were mainly used for falls or bruises/ skin tears, grievance forms, which could be filled out for family complaints, and also had forms called Problem/ Resolution forms, which could be used if there were any concerns involving staff. RN-B stated she had not been involved in making any reports to the state agency in the last 7 months, and was not aware accusations staff mistreatment to residents. When RN-B was asked specifically about the incidents involving R52, R58, R12, R47 and R44, RN-B stated she was aware of those incidents, but there was no injury and those were considered more, "Misunderstandings" then actual mistreatment. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
21850	Continued From page 72	21850		

the investigation the facility determined the staff member had "done something to the resident," they would be suspended. 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 investigation of alleged mistreatment by, "Watching to see if there is any changes in behavior..." The DON stated there were no residents in the past 8 months they had needed to monitor for behavior changes related to allegations of staff maltreatment. The DON stated the facility did not feel everything related to allegations of staff mistreatment needed to be documented, and some things could be determined just by checking with a staff member on the incident. DON acknowledged there was no current system to ensure all allegations were being reported and investigated, nor was there a system in place to track and trend staff involved in resident mistreatment allegations to determine if any staff had a pattern. DON stated staff were not trained to use a certain form to document concerns of resident mistreatment, and the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
21850	Continued From page 73 had multiple forms including incident reports, grievance forms, and problem/ resolution forms. DON stated some of these forms were kept in a binder in the social workers office, some were in employee files, and some were in a file cabinet in her office. The DON verified the facility had no system to track resident mistreatment. During follow up interview on 11/19/14, at 12:10 a.m. administrator stated he felt like he was involved in the investigation process at the facility. The administrator stated he would expect if there was a complaint of resident mistreatment, the supervisor would listen to the complaint, evaluate it, investigate to the extent warranted immediately, and report to him, "Accordingly." The administrator stated he communicated with the DON about resident 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, "Result in injury." The administrator also stated he was aware residents have felt that staffs communication with them have been, "Less then desired by the resident." The administrator stated staff are aware the need to report to the administrator immediately any allegations of resident mistreatment. He stated, "If it gets to me, if it rises to the level of mistreatment, we 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	21850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ___ B. WING ___	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21850	Continued From page 74	21850		

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 faciltiy 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.

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. This

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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
21850	Continued From page 75	21850		

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.

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 maltreatment 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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
21850	Continued From page 76 Suggested Method of Correction: The director of nursing (DON) could work with the administrator to ensure the abuse prohibiton policy is implemented as written to ensure allegations of resident mistreatment is investigated and reported. The DON, administrator, or designee could perform audits to ensure reports are made to the state agency of allegations of reisdent maltreatment. Time Period for Correction: Fourteen (14) days	21850		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the	22000		12/20/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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22000	Continued From page 77 risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, 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 currently	22000	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ____ B. WING ____	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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22000	Continued From page 78	22000		

Continued From page 78

residing in the facility.

The IJ began on 11/19/14, at 4:19 p.m., when the facility failed to report to the administrator and state agency, investigate, and implement interventions to ensure residents were protected from staff mistreatment to ensure residents were free from staff abuse. The administrator and director of nursing (DON) were notified of the immediate jeopardy (IJ) for all 36 residents in the facility on 11/19/14, at 4:19 p.m. The IJ was removed on 11/24/14, at 1:07 p.m. but noncompliance remained at a widespread scope and severity level, with potential for actual harm.

Findings include:

R52's Face Sheet dated 11/20/14, identified diagnoses including hip joint replacement, scoliosis, and pain in the pelvic region and thigh.

R52's quarterly Minimum Data Set (MDS) dated 10/23/14, identified R52 had no cognitive impairment and required extensive weight bearing assistance from two staff for transfers.

During interview on 11/17/14, at 3:34 p.m. R52 stated a few weeks ago, a male nursing assistant (NA) grabbed her on the arm during a transfer from the wheelchair to the bed, and was so rough she hit her hip on the nightstand table. R52 stated she, "Hollered and screamed from the pain," because the transfer was so rough. R52 stated she reported the incident to the registered nurse (RN) case manager, but no one from the facility had spoke to her about the incident.

During another interview on 11/8/14, at 2:53 p.m. R52 again shared her concerns of rough treatment from a staff member during a transfer,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ____ B. WING ____	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

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22000	Continued From page 79	22000		

and stated she thought the NA was too rough when he assisted her and didn't understand what it was like to be in pain. R52 stated the NA had not provided cares to her since this incident, but she would, "Shy away," from that NA if he were to provide cares to her again due to the pain he caused during the last time he assisted her to transfer.

During interview on 11/18/14, at 3:35 p.m. DON stated she was aware of R52's allegation of a male NA transferring her roughly, and she had spoken with both R52 and the NA about the incident. The DON confirmed no report had been made to the SA or administrator regarding the allegation, and there was no documented investigation determining what had happened.

During interview on 11/18/14, at 6:29 p.m. social service (SS)-A and the DON were interviewed regarding R52's complaint of rough treatment by the NA. SS-A stated R52's family had called her and reported R52 was upset about rough treatment by staff during a transfer. SS-A stated she had talked to the NA and charge nurse about the incident, however, SS-A stated she had not documented the investigation regarding the findings of the interviews, and she did not report this to the state agency or administrator. SS-A and DON stated they had spoken with R52 about the incident, and the resident did not experience any injury, so they didn't believe the allegation met the definition of potential abuse, neglect, or mistreatment, and determined no report needed to be made to the state agency. SS-A and DON stated there was no documentation regarding any investigation or interviews, and the NA who was accused of rough treatment of R52 had no further training or monitoring to ensure further resident mistreatment did not occur.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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 80	22000		

During interview on 11/18/14, at 3:27 p.m. RN-B stated she was aware R52 had concerns about a month ago regarding being transferred roughly by a NA. RN-B stated interviews had been completed with the NA accused of transferring R52 roughly, as well as with R52, but she had not documented any of the investigation, nor had she reported R52's accusation of rough treatment to the administrator or state agency. RN-B did not feel this met the definition of resident mistreatment that needed to be reported to the administrator or state agency because R52 did not experience any injury, and RN-B 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 to the state agency if it rose to the level of mistreatment, for example, if 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 immediately after it had happened, however, he stated he knew the NA accused of the rough transfer with R52, and he did not believe the NA would intentionally mistreat a resident.

R58's quarterly MDS dated 10/2/14, indicated R58 had severely impaired cognition, and required assistance with all ADL's, including eating.
Review of a facility Problem Resolution form dated 8/7/14, indicated R58 was eating in the dining room and NA-D was overheard telling R58, "You have to eat, there is nothing in your mouth so there is no reason why you won't eat!" NA-D

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ____ B. WING ____	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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 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 8/8/14, by the RN case manager. [NA-D] stopped in DON office on 8/11/14, to apologize for the incident." There was no further investigation of the mistreatment to R58, and it was not reported to the state agency or administrator.
During interview on 11/19/14, 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 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 had no ongoing effects from the incident.
During interview on 11/19/14, at 2:36 p.m. DON stated when she spoke to NA-D about the incident with R58, NA-D knew how she acted was wrong, and NA-D stated it would not happen again. DON stated NA-D did not receive re-education or corrective action, NA-D was not being monitored to observe her interaction with other residents, there was no further investigation of the incident, and it was not reported to the state agency or administrator. DON did not feel this was abuse or mistreatment because R58 was not harmed, and NA-D knew her actions were not acceptable and apologized.
R44's annual MDS dated 10/2/14, indicated the resident had diagnoses including Alzheimer's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	**410 WEST MAIN STREET OSAKIS, MN 56360**

(X4) ID 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 82 disease, had moderately impaired cognition, and required assistance of one staff with activities of daily living (ADL's), and set up assistance with meals. The facility provided an untitled document, which was kept in the DON's office, indicating on 11/3/14, NA-D brought R44 to the dining room in his wheelchair and the dining room was not opened for breakfast yet. The untitled 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 sitting in the hallway in his wheelchair and walked away, and RN-C assisted R44 to get a snack. The untitled 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 she reported it to the DON. On 11-3-14, NA-D, RN-C, and 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 or other residents. During interview on 11/19/14, at 2:36 p.m. the DON stated NA-D had 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	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ____ B. WING ____	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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 83	22000		

there was no further investigation, nor had the incident been reported to the state agency or administrator. 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, written by RN-C regarding concerns with NA-D and resident mistreatment, indicated NA-D was, "What I felt as demeaning to a resident at noon meal, stating rudely that a resident could feed herself, even though this resident does need more assistance to feed herself." There was no follow up with NA-D regarding RN-C concerns of being rude to the resident or possible neglect of providing necessary care. During multiple interviews with staff, no one was able to recall who the resident was NA-D had been rude to. The incident was not reported to the state agency or administrator, and there was no further investigation.

R47's Admission Record dated 11/11/14, included diagnoses of Alzheimer's disease and urinary incontinence. R47's quarterly MDS dated 8/18/14, identified R47 had severe cognitive impairment, was incontinent of bowel and bladder, required extensive assistance of two staff for bed mobility, and was totally dependent on staff for toileting and personal hygiene.
During interview on 11/18/14, at 11:19 a.m. FM-A stated while visiting R47 about five months ago, she stepped out of R47's room into the hallway while two nursing assistants provided personal cares for R47. FM-A heard R47 moaning, and went into R47's room to check on her. FM-A stated she pulled back the privacy curtain, and witnessed an unidentified NA holding R47 onto

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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 rough...It was a one-time thing...There wasn't a lot to it...It 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. This incident was not reportable." SS-A stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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 85 she did not report the incident to the administrator, and did not know if it was in their policy that she needed to report the incident to the administrator if it was not considered abuse. SS-A could not recall who the employees were accused of being rough with R47, and stated nothing would be in the employees personal file because it was not determined there was any mistreatment to R47. This was not reported to the state agency or administrator. During interview on 11/19/14, at 9:00 a.m. DON stated when a complaint is received, the facility should review the incident, "To see if it's reportable...whoever receives the concern follows up with the family...You don't want to over report...If 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,	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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 86	22000		

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.

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 without toileting R12. 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(X4) ID 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 87	22000		

Continued From page 87

During interview on 11/18/14, at 11:45 a.m. an unidentified visitor at the facility stated on 11/7/14, they had overheard R12 ask NA-J for assistance to use the restroom. NA-J stated to R12, "I told you that when I was done, I would help you. Now be quiet!" The visitor stated she had not told anyone at the facility about this, but stated this had made her uncomfortable as she felt the staff were very rude.

During interview on 11/21/14, at 10:07 a.m. DON stated the reported incident/ grievance of staff mistreatment involving R12, which was documented on the grievance form dated 11/12/14, had not been reported to the administrator or the SA. DON had no investigation of the incident, and could not verify if any staff were interviewed or re-educated regarding toileting R12 and being rude to the resident.

During interview on 11/18/14, at 11:45 p.m. RN-B stated if the facility had a accusation of staff mistreatment, it would depend on the severity of allegation to determine the investigation, if it required reporting, and if it would be documented. RN-B stated the facility had incident reports, which were mainly used for falls or bruises/ skin tears, grievance forms, which could be filled out for family complaints, and also had forms called Problem/ Resolution forms, which could be used if there were any concerns involving staff. RN-B stated she had not been involved in making any reports to the state agency or administrator in the last 7 months, and was not aware accusations staff mistreatment to residents. When RN-B was asked specifically about the incidents involving R52, R58, R12, R47 and R44, RN-B stated she was aware of those incidents, but there was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00109	A. BUILDING: ______ B. WING ______	11/24/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 88	22000		

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 investigation of alleged mistreatment by,

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	00109	A. BUILDING: ______ B. WING ______	11/24/2014

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22000	Continued From page 89	22000		

"Watching to see if there is any changes in behavior..." The DON stated there were no residents in the past 8 months they needed to monitor for behavior changes related to allegations of staff mistreatment. The DON stated the facility did not feel everything related to allegations of staff mistreatment needed to be documented, and some things could be determined just by checking with a staff member on the incident. DON acknowledged there was no current system to ensure all allegations were being reported to the state agency and administrator, and thoroughly investigated, nor was there a system in place to track and trend staff involved in resident mistreatment allegations to determine if any staff had a pattern. DON stated staff were not trained to use a specific form to document concerns of resident mistreatment, and the facility had multiple forms including incident reports, grievance forms, and problem/ resolution forms. DON stated some of these forms were kept in a binder in the social workers office, some were in employee files, and some were in a file cabinet in her office. The DON verified the facility had no system to track resident mistreatment or to ensure all allegations of resident mistreatment were reported to the administrator and SA.

During follow up interview on 11/19/14, at 12:10 a.m. administrator stated he felt like he was involved in the investigation process at the facility. The administrator stated he would expect if there was a complaint of resident mistreatment, the supervisor would listen to the complaint, evaluate it, investigate to the extent warranted immediately, and report to him, "Accordingly." The administrator stated he communicated with the DON about resident incidents daily and stated, " We communicate daily; we park in the

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22000	Continued From page 90	22000		

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, "Result in injury." The administrator also stated he was aware residents have felt that staffs communication with them have been, "Less then desired by the resident." The administrator stated staff are aware the need to report to the administrator immediately any allegations of resident mistreatment. He stated, "If it gets to me, if it rises to the level of mistreatment, we 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 had a very small facility, so management feels like they know their 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

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22000	Continued From page 91 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 faciltiy 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.	22000		

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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