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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: U7KG

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

Facility ID: 00800

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245401**

2.STATE VENDOR OR MEDICAID NO.
(L2) **936540100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CENTRAL HEALTH CARE**
(L4) **444 NORTH CORDOVA**
(L5) **LE CENTER, MN** (L6) **56057**

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 **03/16/2021** (L34)

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

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

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

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

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 40 | | | |
| (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 :
Elizabeth Silkey, Unit Supervisor — 03/25/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Melissa Poepping, Enforcement Specialist — 03/25/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
**12/01/1986**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**00131**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
March 25, 2021

CMS Certification Number (CCN): 245401

Administrator
Central Health Care
444 North Cordova
Le Center, MN 56057

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective March 19, 2021 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered
March 25, 2021

Administrator
Central Health Care
444 North Cordova
Le Center, MN 56057

RE: CCN: 245401
Cycle Start Date: February 3, 2021

Dear Administrator:

On March 16, 2021, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: U7KG

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

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(L3) **CENTRAL HEALTH CARE**
(L4) **444 NORTH CORDOVA**
(L5) **LE CENTER, MN** (L6) **56057**

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 **02/03/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

| | | | | |
|---|---|---|---|---|
| 01 Hospital | 05 HHA | 09 ESRD | 13 PTIP | 22 CLIA |
| 02 SNF/NF/Dual | 06 PRTF | 10 NF | 14 CORF | |
| 03 SNF/NF/Distinct | 07 X-Ray | 11 ICF/IID | 15 ASC | |
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FISCAL YEAR ENDING DATE: (L35)
**09/30**

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___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)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 40 | | | |
| (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 :
Julie Halvorson, HFE NE II 03/15/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 03/24/2021 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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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
**12/01/1986**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
**00131**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
February 25, 2021

Administrator
Central Health Care
444 North Cordova
Le Center, MN 56057

RE: CCN: 245401
Cycle Start Date: February 3, 2021

Dear Administrator:

On February 3, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

## ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

## DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

## 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 May 3, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by August 3, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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

## INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245401 | A. BUILDING _____ B. WING _____ | C 02/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CENTRAL HEALTH CARE** | **444 NORTH CORDOVA LE CENTER, MN 56057** |

| (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 |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 2/1/21 - 2/3/21, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On 2/1/2021, through 2/3/2021, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were found to be UNSUBSTANTIATED:<br>H#5401037C (MN#60787)<br>H#5401038C (MN#65395)<br>H#5401039C (MN#63904)<br>H#5401040C (MN#65378)<br>H#5401041C (MN#64564)<br><br>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.<br><br>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 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 03/04/2021 |

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 |
|---|---|---|---|
| | 245401 | A. BUILDING _____ B. WING _____ | C 02/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CENTRAL HEALTH CARE** | **444 NORTH CORDOVA LE CENTER, MN 56057** |

| (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 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.<br>Follow-up procedures must be in place to provide | F 578 | | 3/4/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245401 | A. BUILDING _____ B. WING _____ | C 02/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CENTRAL HEALTH CARE** | **444 NORTH CORDOVA LE CENTER, MN 56057** |

| (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 578 | Continued From page 2<br>the information to the individual directly at the appropriate time.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure physician orders for life sustaining treatment (POLST) matched the resident's plan of care for 1 of 1 resident (R22) reviewed for advance directives (AD).<br><br>Findings include:<br><br>R22's face sheet dated 2/3/21, indicated R22 was admitted to the facility on 2/26/2018. The face sheet identified R22 as having diagnosis of hypertension (HTN), history of atrial fibrillation (AF), hyperlipidemia, bi-fascicular block on right bundle branch block, long term use of anticoagulants and edema.<br><br>R22's annual minimal data set (MDS) assessment dated 1/6/21, identified R22 as having severe cognitive impairment.<br><br>R22's Physician Orders for Life-Sustaining Treatment (POLST) dated 3/2/18, indicated Do Not Attempt Resuscitation (DNR), allow natural death and comfort focused treatment. R22's additional preference included no artificial nutrition by tube and OK for use of intravenous (IV) or Intramuscular (IM) antibiotic treatment.<br><br>R22's Physician Orders for Life-Sustaining Treatment (POLST) dated 10/30/20, indicated Do Not Attempt Resuscitation (DNR), allow natural death and comfort focused treatment. The POLST did not include any additional preferences. | F 578 | F-tag 578 Request/Refuse/Discontinue Treatment;Formlte Adv Dir (Long Term Care Facilities)<br>CFR(s): 483.10 (c)(6)(8)(g)(12)(i)-(v)<br><br>Social Services will review and complete the POLST form upon admission with all new residents and/or resident representative.<br>A copy of the signed POLST form by resident or representative will be filed in the resident□s chart and the original will be kept in the resident□s soft file in the social service office.<br>The POLST form will be sent to the resident□s provider for a signature and will be requested to be returned as soon as possible to the facility.<br>Once the physician has signed and returned the form to the facility, the signed copy will be filed in the resident□s chart.<br>Once both documents are complete, there should be two POLST forms in the resident□s chart □ 1 unsigned by the physician and 1 signed by the physician.<br>Nursing staff or HUC will update resident□s physician orders and enter information in the resident□s MAR/TAR with the code status.<br>All residents Advanced Directives/POLST forms will be reviewed with resident and POA quarterly and annually at Care Conference.<br>Social Services consultant or designee will complete weekly audits to ensure | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245401 | A. BUILDING _____ B. WING _____ | C 02/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CENTRAL HEALTH CARE** | **444 NORTH CORDOVA LE CENTER, MN 56057** |

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|---|---|---|---|---|
| F 578 | Continued From page 3<br>R22's plan of care dated 1/21/20, included a DNR/DNI status with additional preferences that included hospitalization, IV hydration, oral antibiotics and IM antibiotics.<br><br>During interview on 2/2/21, at 12:09 p.m. registered nurse (RN)-B indicated when staff determine a residents AD status it is located on the residents face sheet in the electronic record, the POLST and the plan of care.<br><br>During an interview on 2/2/21, at 12:39 p.m. the health unit coordinator (HUC) indicated it was her responsibility to scan an updated POLST into the residents medical record initially and with any updated changes. The HUC was unsure of who was responsible for updating a residents plan of care.<br><br>During an interview on 2/2/21, at 12:44 p.m. the facility social services director (SSD) indicated when there is a change in a residents POLST the nursing staff would be responsible for updating the residents care plan.<br><br>During an interview on 2/2/21, at 1:56 p.m. the assistant director of nursing (ADON) indicated she thought the SSD was responsible for updating the care plan if there was a change in a residents POLST.<br><br>During an interview on 2/2/21, at 2:11 p.m. the director of nursing (DON) confirmed R22's plan of care had not been updated according to R22's current POLST. The DON indicated it was the ADON or the DON's responsibility to update the plan of care when changes in the POLST are made. | F 578 | compliance.<br>POLST Form Policy & Procedure was updated on 2/9/2021. A read & sign education on this policy & procedure was posted for the nursing staff on 2/9/21 and was completed on 2/18/21.<br>All data/audits and any issues related to Advanced Directive/POLST forms have been added to the QAPI Agenda and will be discussed and amended at monthly QAPI meetings until it is determined compliance is successful.<br>Date of Compliance 2/18/2021 | |

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| F 578 | Continued From page 4<br>During an interview on 2/3/21, at 10:48 a.m. the SSD confirmed R22's current plan of care did not match R22's most current POLST. R22's care plan indicated R22's AD included hospitalization, IV hydration, IV medication, oral antibiotics and intramuscular antibiotics. R22 most recent POLST did not include the above preferences.<br><br>Review of the facility POLST Policy and Procedure dated 2/3/21, indicated a resident's care plan would reflect the resident's current POLST status. | F 578 | | |
| F 582 SS=D | Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must--<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the | F 582 | | 3/4/21 |

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| F 582 | Continued From page 5<br>facility's per diem rate.<br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.<br>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure the Skilled Nursing Facility Advanced Beneficiary Notice was given to 2 of 6 residents (R125 and R126) reviewed who received Medicare Part A services upon discontinuation of Medicare part A benefits, as required.<br><br>Findings include: | F 582 | F-tag 582 Medicaid/Medicare Coverage/Liability Notice CFR9s): 483.10(g)(17)(18)(i)-(v)<br>.<br>IDT will discuss in morning stand up meeting when a resident will be discharging from skilled services/Medicare coverage.<br>The day of last coverage will be determined, and the ABN & Notice of | |

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| F 582 | Continued From page 6<br>The facility could not provide CMS-20052 form, Skilled Nursing Facility Beneficiary Protection Notification Review, or any documentation that R125 received form CMS-10055 Advanced Beneficiary Notice, or CMS-10123 Notice of Medicare Non-Coverage, nor was there documentation in R125's medial record of a conversation of the options. R125's Part A coverage started 10/16/20 and ended 11/23/20.<br><br>R126's CMS-20052 form completed by the facility revealed R126's Medicare Part A services started 08/25/20, and the last covered day of Part A service was 09/24/20. The form indicated no for CMS-10055 and yes for CMS-10123, however the facility Notice of Medicare Non-Coverage form was not found. Additionally, there was no documentation in R126's medical record that the form was discussed or signed.<br><br>On 02/03/21, at 4:24 p.m. social worker consultant (SW)-A verified social services could not provide documentation for R125's and R126's CMS-20052, CMS-10055, or CMS-10123, nor was there any documentation in the resident's chart indicating the process had been completed. SW-A indicated a plan of correction had been created to prevent the event from reoccurring.<br><br>The facility Advanced Beneficiary Notice (ABN) and Notice of Medicare Non-Coverage policy dated 2/9/2021, directed social services to meet with the resident the day prior to coverage ending and discuss end of coverage options. Further, a progress note will be entered into the resident's chart indicating the meeting took place, the forms scanned into the resident's chart and the original placed in the resident's soft file in social services. | F 582 | Medicare Non-Coverage will be reviewed with the resident the day before to inform them. Resident and/or resident representative will sign the notice acknowledging receipt.<br>Resident and/or representative will be given a copy of the ABN & Medicare non-coverage notice that same day.<br>The ABN & Medicare Non-coverage date will be filed in the resident's chart under resident documents tab.<br>The original ABN & Medicare non-coverage notice will be filed in resident's soft file in the social service office and a copy of the forms will be given to the facility business office manager. A progress note will be documented in the resident's chart stating that the notice was provided to the resident and whether resident signed the notice or would like to wait for the Medicare denial statement. Date of Compliance: 2/9/2021.<br>Social Services consultant or design will complete weekly audits to ensure compliance.<br>ABN/Notice of Medicare Policy & Procedure was created on 2/9/2021. A read & sign education was completed with both employees in the social service department on 2/17/21.<br>Date of Compliance 2/17/2021 | |

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| F 658 | Continued From page 7 | F 658 | | |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure professional standards of practice were followed during administration of eye drops for 2 of 2 residents (R4 and R9) observed for medication administration, when drops were placed incorrectly.<br><br>Findings include:<br><br>R4's facesheet, printed on 2/3/21, indicated diagnoses of dry eye syndrome.<br><br>R4's annual Minimum Data Set (MDS) assessment dated 10/28/20, indicated R4 had moderate cognitive impairment, moderately impaired vision, clear speech, was usually understood and was usually able to understand. R4 required limited assistance of one for most activities.<br><br>R4's plan of care with problem start date of 2/18/20, indicated R4 had impaired vision due to advanced aged. Eye drops were to be administered as ordered with staff observing for side effects and effectiveness, and to explain all procedures and care thoroughly to R4 before doing them.<br><br>Physician orders initiated on 6/8/16, indicated R4 | F 658 | F-tag: 658-Services Provided Meet Professional Standards CFR(s): 483.21 (b)(3)(i)<br><br>The Director of Nursing and ADON completed competency and skill assessment check list with the Nurses and Trained Medication Assistants on the Ophthalmic drop policy and the correct process of instilling eye drops to meet professional standards of quality. Nursing staff presented correct technique of administrating drops upon return demonstration. (initiated 2/5/2021 and completed on 2/9/2021)Date of Compliance: 2/9/2021.<br><br>All residents who are prescribed eye medications have been identified. The Director of Nursing or designee will conduct twice daily audits x 3 weeks, then weekly audits x 4 weeks, then randomly to ensure correct process is followed. Ophthalmic Medication Competency check list has been placed in new nursing/TMA employee orientation packet. (initiated 2/5/2021 and completed 2/26/2021). | 3/4/21 |

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| F 658 | Continued From page 8 | F 658 | | |

was to receive Systane Gel eye drops, one drop to both eyes three times a day for dry eyes.

During an observation on 2/1/21, at 4:00 p.m., R4 was sitting in a wheelchair in her room. Licensed practical nurse (LPN)-C informed R4 she had her eye drops. LPN-C placed the tip of the eye drop bottle at the inner corner of each eye to instill drops. LPN-C did not ask R4 to tilt her head back, nor did LPN-C attempt to manipulate eyes in an effort to place drop in the pocket of the lower lid (conjunctival sac).

R9's facesheet, printed on 2/3/21, indicated age-related cataracts in both eyes and dry eye syndrome of left eye.

R9's annual Minimum Data Set (MDS) assessment dated 11/11/20, indicated R9 had severe cognitive impairment, minimal difficulty hearing, adequate vision, clear speech, was usually understood and was usually able to understand. R9 required limited assistance or supervision for transfers, walking, and locomotion on and off the unit.

R9's plan of care, with problem start date of 2/25/20, indicated R9 had cognitive impairment and to give clear and simple directions and explanations. R9's care plan did not have a category specific to vision.

Physician orders indicated R9 was to receive the following eye drops:
1. Betimol, 1 drop in left eye twice daily for age related cataract, initiated on 4/17/19
2. Dorzolamide, 1 drop in left eye three times a day for age related cataract, initiated on 9/27/19
3. Brimonidine, 1 drop in left eye three times daily

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| F 658 | Continued From page 9<br>for age related cataract, initiated on 3/27/20<br>4. Latanoprost, 1 drop in left eye at bedtime for dry eye syndrome, initiated on 3/27/20<br>5. Systane Ultra, 1 drop as needed to both eyes for age related cataract, initiated on 6/22/20<br>6. Systane, 1 drop in both eyes every 6 hours for age related cataract, initiated on 1/28/21<br><br>During an observation on 2/1/21, at 5:15 p.m., R9 was sitting in a recliner in his room. LPN-C informed R9 she had his eye drops (Systane). LPN-C asked R9 to tilt his head back, but did not wait for him to do so nor did she assist him in tilting his head back. LPN-C placed the tip of the eye drop bottle at the inner corner of each eye to instill the drops. LPN-C did not attempt to manipulate either eye in an effort to place drops in the pocket of each lower lid. When asked if she thought the drops got into the eyes when placing the tip in the corner of the eyes, LPN-C replied by saying "oh yes."<br><br>During an observation on 2/2/21, at 11:26 a.m., R9 was sitting in a recliner in his room. Registered nurse (RN)-A informed R9 she had his eye drop (Brimonidine). RN-A placed the bottle very close to the inner corner of the left eye to instill the drop. RN-A did not attempt to manipulate the left eye in an effort to place drop in the pocket of the lower lid. When asked if she thought the drop got into the eye when placing the tip in the corner of the eye, RN-A shook her head affirmatively.<br><br>During an observation on 2/2/21, at 11:37 a.m., R9 was sitting in a recliner in his room. RN-A informed R9 she had his eye drop (Dorzolamide). RN-A helped R9 tilt his head back very slightly and manipulated the left eye with two fingers to | F 658 | | |

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| F 658 | Continued From page 10<br>open it slightly and instilled a drop in the inner corner of the eye.<br><br>During an interview on 2/3/21, at 4:03 p.m. with both the administrator and director of nursing (DON), the DON was asked to describe how she expects staff to administer eye drops to residents. The DON stated she would approach the resident, explain what she was going to do, ask resident to tilt head back, bring down the lower lid with her finger and instill the drop in the center of the lower lid. When informed of observations of staff not using this technique, DON stated she was not aware of this. The administrator stated they would provide re-education to staff on instilling eye drops correctly.<br><br>Facility policy titled Ophthalmic Drops, with reviewed date of December 2020, indicated:<br>1. Explain procedure.<br>2. Head should be tilted back and toward side of affected eye.<br>3. Hold cotton ball or clean tissue in non-dominate hand just beneath eye lid.<br>4. Before instilling drop, instruct resident to look up and away.<br>5. Gently pull down lower lid to expose conjunctival sac (located between the inside of the lower eyelid and eyeball).<br>6. Hold dropper 1/2 to 3/4 inch above conjunctival sac.<br>7. Have resident close eyes gently and roll eyes. | F 658 | | |
| F 685 SS=D | Treatment/Devices to Maintain Hearing/Vision<br>CFR(s): 483.25(a)(1)(2)<br><br>§483.25(a) Vision and hearing<br>To ensure that residents receive proper treatment and assistive devices to maintain vision and | F 685 | | 3/4/21 |

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| F 685 | Continued From page 11<br>hearing abilities, the facility must, if necessary, assist the resident-<br><br>§483.25(a)(1) In making appointments, and<br><br>§483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide assistance to ensure hearing aids (HA's) or other adaptive devices were available to maintain hearing/communication needs for 1 of 1 resident (22) reviewed for hearing.<br><br>Findings include:<br><br>R22's annual minimal data set (MDS) dated 1/6/21, identified R22 as having severe impairment with cognition with a brief interview for mental status (BIMS) score of 7. R22 had minimal difficulty with hearing and wore HA's in both ears. R22 usually understood others with his hearing aides. R22 required extensive assist of 1 staff with bed mobility and assist of two staff for transfers from bed to standing position. R22 is unsteady with transfers from sitting to standing and required staff assist to stabilize. R22 had an impairment on one side of his upper and lower extremity.<br><br>R22's care plan dated 1/21/20, indicated R22 had difficulty making needs known related to hearing loss. R22 wore bilateral HA's. Staff were directed to speak to R22 slowly, clearly, repeat | F 685 | F-tag 685 Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2)<br><br>Resident R-22's Care Plan was reviewed and updated to ensure resident Hearing Aides are turned over to nurse and visibly verified before signing off in the ETAR. Resident R-22's Care plan was updated to include offering alternative means of communication should hearing aides are misplaced.<br><br>A Hearing Aide Storage Policy was drafted on 2/3/2021 and a Missing Hearing Aide/Vision Policy was drafted on 2/7/2021.<br><br>All residents who require hearing aides that require storage in the nurse cart have been identified. A read and sign education policy was reviewed with nursing on 2/3/2021 and completed on 2/9/2021. Hearing Aide storage for identified residents has been added on the Care Plan, Care Sheets and ETAR, and is monitored for compliance by the nurses. | |

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| F 685 | Continued From page 12<br>themselves and adjust their tonal quality as needed. R22 required extensive assist of 2 staff with bed mobility and transfers.<br><br>During observation and interview on 2/1/21, at 4:53 p.m. R22 was sitting in his recliner in his room. The television (TV) was extremely loud and made it difficult to have any kind of conversation with the resdient. R22 turned the TV volume down for the interview. During interview R22 continued to have a difficult time hearing, even with a louder tone of voice. R22 was observed to not have HA's in his ears or any other adaptive hearing device. R22 indicated he wore HA's in both ears to hear, but they had been missing for a few days. R22 was unsure how long he had been without HA's. R22 did share he was having a difficult time communicating, and it bothered him enough to affect his quality of life. R22 further added it makes it difficult to enjoy watching TV as well as not understanding what people are saying. When asked R22 if staff offered him any kind of adaptive device to use for communication, he indicated they had not.<br><br>During observation on 2/2/21, at 11:14 a.m. R22 continued to not have any HA's in his ears or adaptiove devices to aid in communication. R22 reported his HA's were still lost. R22 continued to have a difficult time communicating and hearing with conversation.<br><br>During an interview on 2/2/21, at 9:23 a.m. the assistant director of nursing (ADON) indicated R22's hearing aides were kept in the medication carts at night and given to the resident in the morning. The ADON added this process was implemented because residents were often misplacing their HA's. The ADON confirmed R22 | F 685 | The Director of Nursing will conduct daily ETAR audits x 4 weeks, then monthly x3. A read and sign education on Missing Hearing Aide/Vision Policy to include alternative devices as needed hearing vision device is missing lost or broken; was posted for all staff on 2/7/2021 and completed on 2/12/2021. Date of compliance: 2.12.2021. | |

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| F 685 | Continued From page 13 | F 685 | | |

currently did not have the ability to remove his HA's independently due to a decline in his upper extremeties range of motion (ROM). The ADON was not aware R22's HA's were missing.

During an interview on 2/2/21, at 11:24 a.m. the administrator indicated she had not been aware of R22's missing HA's. The administrator indicated when staff identify a missing item, the policy is to fill out a "Missing Item Report". This would inform administration so that an investigation should be initiated. The administrator confirmed there had been no missing item report filled out for R22's missing HA's.The administrator reported it was her expectation that staff complete a missing item report, when a missing item is identified.

During an interview on 2/2/21, at 11:59 a.m. nursing assistant (NA)-A indicated if a residents personal item is identified missing, the nursing staff is directed to report to the charge nurse immediately. The charge nurse would then follow up on the missing item.

During an interview on 2/2/21, at 12:15 p.m. registered nurse (RN) -A indicated licensed practical nurse (LPN)-B reported to her on 1/31/21, R22's hearing aides were missing. RN-A further indicated she had forgot to follow up on the missing HA's.

During an interview on 2/2/21, at 12:47 p.m. LPN-B indicated she had last seen R22's HA's on Friday (1/29/21).

During an interview on 2/2/21, at 2:21 p.m. the director of nursing (DON) indicated she would expect facility staff to search for the missing HA's

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| **CENTRAL HEALTH CARE** | **444 NORTH CORDOVA LE CENTER, MN 56057** |

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| F 685 | Continued From page 14<br>when identified. Staff should fill out a "Missing Item" report if the item is not found.<br><br>During an interview on 2/3/21, at 10:34 a.m. the facility health unit coordinator (HUC) indicated she thought R22 lost his HA's when NA-B gave R22 a bath on 1/30/21. LPN-C spoke to NA-B and verified R22's HA's were taken out during his bath, and may have been lost during that time.<br><br>During an interview on 2/3/21, 10:39 a.m. R22 reported he continued to struggle with hearing and confirmed the facility had not provided any alternatives to aid in communication. R22 indicated he had not been informed if staff were looking for his HA's or what may have happened to them. R22 expressed frustration when trying to communicate and hear with conversation, as well as not being able to hear his TV.<br><br>During an interview on 2/03/21, on 11:03 a.m. NA-C indicated the facility had not provided alternatives to aid R22 with communication, since his HA's had been identified missing. NA-C further added a hearing amplifier could have helped R22 with communicating while his HA's were missing. NA-C confirmed R22 was having increased difficulty hearing without his HA's.<br><br>Review of the facility policy Hearing Aide Storage Policy dated 2/3/21, directed staff to follow facility protocol if hearing aids were misplaced. The facility protocol is to initiate a search and fill out a "Missing Items Report" if the hearing aides are not found within 4 hours after reported missing. | F 685 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) | F 689 | | 3/4/21 |

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| F 689 | Continued From page 15<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to follow the facility Smoking Evaluation Tool safe smoking interventions for 1 of 3 residents (R1) reviewed for smoking and allowed smoking in a non-designated smoking area.<br><br>Findings include:<br><br>R1's Admission Record printed 02/03/21, indicated R1 was admitted with post-polio syndrome, chronic obstructive pulmonary disease, and nicotine dependence.<br><br>R1's annual Minimum Date Set (MDS) assessment dated 01/20/21, indicated R1 was cognitively intact and able to make independent decisions and did not require assistance with activities of daily living. The MDS Section Section J-1300 identified R1 as a current tobacco user.<br><br>R1's current physician orders printed 02/03/21, listed R1 as prescribed an anti-depressant medication and to monitor/observe for signs of sedation, drowsiness, blurred vision, and muscle tremor. Additionally, R1 is prescribed an antipsychotic medication and to monitor/observe for mild sedation. | F 689 | F-tag 689: Free of Accidents/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>Resident R1's smoking assessment and care plan has been updated to ensure appropriate measures are in place for storing lighters/ignition sources at the nursing cart. Director of Nursing and Social Service Coordinator met with the resident and reviewed the facility Lighter/Ignition Source Policy with the resident. The resident is alert & oriented, and did agree to turning in lighters/ignition sources with the nursing staff for safety.<br><br>Nurses and TMA□s received education on the Lighter/Ignition Source Policy. These items are to be kept on the nurse's cart and given to resident R1 upon request and turned in after coming in from smoking. The Director of Nursing or Designee will audit for compliance daily x 4 weeks to ensure these materials are being turned in, then weekly x 4 weeks, then monthly. Smoking has been added to the QAPI agenda. All data and audits and any issues related to tobacco use will be discussed and amended at monthly | |

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| F 689 | Continued From page 16<br>R1's care plan dated 11/05/19, identified R1 as a tobacco user in the form of cigarettes. R1's safe smoking interventions dated 08/24/20, directed R1 is to turn his lighter over to nursing when not in use. Further, lighters or matches are not to be kept in residents' rooms due to safety purposes. Resident agrees to the plan and the lighter has been removed from room, labeled, and placed on the nursing medication cart.<br><br>During interview on 02/03/21, at 2:28 p.m. MDS Coordinator verified R1 was a smoker and documented upon MDS Section J-1300 as a current tobacco user.<br><br>A Progress Note dated 11/26/20, at 9:32 a.m. documented R1 laid in bed most of shift and goes outside to have a cigarette.<br><br>R1's annual Smoking Evaluation Tool assessment completed by assistant director of nursing (ADON) on 01/20/21, identifef interventions including: resident wears smoking apron and the lighter is kept at the nurse's station. ADON documented R1 can come to desk to ask for the lighter and then return it to nurse at the desk.<br><br>During an observation on 02/02/21, at 8:44 a.m. R1 went outside to smoke, approximately 12 feet from the front entrance door. R1 was unattended and did not have a smoking apron on. R1 was not observed getting a lighter from staff or returning it to staff when he returned to the building.<br><br>During an observation on 02/03/21, at 2:48 p.m. R1 went outside to smoke, approximately 12 feet from the front entrance door. R1 was not observed receiving smoking material from the | F 689 | QAPI meetings until it is determined that compliance is successful. (date of compliance: 2/4/2021.)<br><br>Smoking evaluations have been reviewed for all residents who have been identified as tobacco users. Evaluations were reviewed and corrected as appropriate to ensure safety measures are in place for storing lighters/ignition sources in the nursing cart and not kept by resident(s) or in their rooms. Two other residents were identified. Per smoking assessments, these 2 residents are identified as requiring supervision when smoking. Lighters/ignition sources and cigarettes for these residents are stored in the medication room as it has been identified these residents are not appropriate to keep in their room. Cigarettes and lighters are picked up and turned in by responsible parties.<br><br>The facility is phasing into a smoke free environment and advises potential residents of policy. Current tobacco users have been grand-fathered in.<br><br>The outdoor smoking area has been assessed and signs alerting smokers they are to be at a 25 foot distance are in place. The ash receptacle has been placed 25 feet away from building.<br><br>The DON or designee will audit all residents for compliance at maintaining a 25-foot distance away from the building while smoking daily x 4weeks, then weekly x 4 weeks, then quarterly. All | |

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| F 689 | Continued From page 17<br>nurses. It was observed there were three nursing staff in the nurse's station as R1 wheeled by the nurse's station. R1 was observed outside without a smoking apron on. R1 returned to the building and wheeled by the nurse's station and did not give staff his lighter or cigarettes.<br><br>During an interview on 02/03/21, at 11:27 a.m. R1 stated keeping his cigarettes and lighter in his nightstand drawer. R1 stated he does not have to wear a smoke apron. R1 reported staff do not have to hold my cigarettes or lighter.<br><br>During an interview on 02/03/21, at 3:23 p.m. the director of nursing DON verified R1 received his smoking assessment on 01/20/21, that indicated R1 wears a smoking apron and R1's lighter is kept at the nurse's station. DON indicated nursing staff are not following the smoking policy and that the lighter is a safety concern and is an ignition source.<br><br>The facility Smoking Policy dated 12/14/20, directed smoking is permitted on the front patio, twenty-five feet from the main entrance door. Additionally, any resident requesting to smoke will be assessed by a member of the interdisciplinary team utilizing the Smoking Evaluation Form and establish individualized safety interventions. | F 689 | data/audits will be discussed/reviewed at monthly QAPI meetings until it is determined compliance is met. | |
| F 700 SS=D | Bedrails<br>CFR(s): 483.25(n)(1)-(4)<br><br>§483.25(n) Bed Rails.<br>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following | F 700 | | 3/4/21 |

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| F 700 | Continued From page 18<br>elements.<br><br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to appropriately assess the use of side rails (including grab bars) prior to use for 1 of 15 residents (R22) reviewed who utilized side rails, to ensure the side rails were applied safely and maintained in a safe manner to prevent possible entrapment and/or accidents based on FDA guidelines.<br><br>Findings include:<br><br>R22's face sheet dated 2/3/21, identified diagnoses including: diabetes, hypertension (HTN), long term insulin use, hemiplegia (paralysis of one side of the body), hemiparesis (weakness or the inability to move on one side of the body) following cerebral infraction affecting right dominate side,cervicalgia (neck pain), diarrhea, and repeated falls. The face sheet identified an admission date of 2/2018. | F 700 | 2/4/2021<br>F-tag: 700-Bedrails CFR(s): 483.25(n)(1)-(4)<br><br>Resident R22's personal bed with grab bar was immediately removed from resident room and replaced with a facility bed with 1 grab bar following approval from resident and resident representative. The Director of Nursing measured using the Bionex Bed System Measurement device tool to assess for risk of entrapment in the grab bar structure. The bed/grab bar passed assessment. Date of Compliance: 2/2/2021.<br><br>All Resident occupied beds with grab bars have been identified and grab bars have been measured using the Bionex Bed System Measurement device tool to assess for risk of entrapment in the grab | |

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| F 700 | Continued From page 19<br>R22's annual Minimum Data Set (MDS) assessment dated 1/6/21, identified R22 as having severe cognitive impairment with a brief interview of mental status (BIMS) score of 7. The MDS indicated R22 required extensive assist of 1 staff with bed mobility and assist of two staff to transfer from bed to a standing position. The MDS also indicated R22 was unsteady with transfers from a sitting to standing position and required staff assist to stabilize.<br><br>R22's care plan dated 1/21/20, identified impaired balance related to diagnoses of hemiplegia and hemiparesis on the right side. The care plan indicated R22 had a grab bar on the outer side of the bed to assist with bed mobility, and indicated R22 required extensive assist of 2 staff with bed mobility and transfers. In addition, the care plan indicated R22 had a personal bed and mattress at standard height which he was safe to use, R22 was able to sit upright at the edge of his bed and could use a grab bar to support himself. The interventions indicated nursing staff were to check the grab bar straps for security on bed frame weekly and tighten as needed. The care plan also identified R22 as being at risk for falls<br><br>R22's adaptive equipment assessment dated 1/5/21, indicated R22 had a grab bar on the outer side of the bed to aide in bed mobility.<br><br>During observation and interview on 2/1/21, at 5:03 p.m. R22's grab bar on the outer side of bed had a large gap observed between the mattress and grab bar. Upon review of the grab bar, the surveyor was able to move the top of the grab bar back and forth and the rail was loose, and shifted outward enlarging the gap between the mattress and bed R22 reported he used the grab bar to | F 700 | bar structure. All occupied resident beds with grab bars have passed. The bed assessment has been added to the resident plan of care. Date of compliance: 2/4/2021.<br>One identified resident who does have ¿ rails x4 placed on his bed for mobility purposes and is being rented by him from a Medical Equipment Rental facility. This bed was assessed using the Bionex Bed System measurement tool. Zones 1,2,3,4 measured following HBSW criteria to assess rail entrapment risk. This bed did pass the assessment and added to Care plan. Date of compliance: 2/4/2021.<br>All beds in the facility with ¿ rails have been measured using the Bionex Bed System measurement tool. Zones 1,2,3,4 measured following HBSW criteria to assess rail entrapment risk. These beds did not pass the bed assessment and pose a risk for entrapment. These beds were not occupied, were tagged and removed from service. Maintenance immediately removed side rails from these beds. Date of compliance: 2/4/2021.<br>All New admits will be evaluated for bed mobility/grab bar use by the therapy department. Once need is determined, Maintenance will install grab bar(s) on the bed. Residents who have a change of mobility/condition requiring grab bars will be assessed by the DON or designee for entrapment risk using the Bionex Bed System Measuring tool and added to the Care Plan. Date of Compliance: 2/4/2021<br><br>Residents and/or family members who request bed rails will be educated on the | |

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| F 700 | Continued From page 20<br>aid in turning and to aid when sitting up in bed.<br><br>On 2/1/21, at 5:10 p.m. the director of nursing (DON) confirmed the large gap between the grab bar and mattress. In addition, the DON acknowledged there was movement with the grab bar. At 5:30 p.m. the DON measured the gap with an entrapment device. The measurement obtained between the grab bar and mattress was 5.5 inches wide. The DON and the administrator confirmed these findings did not meet the FDA requirements to prevent. Further the DON saff were directed to check the grab bar weekly and tighten as needed, and had identified the loose grab bar on 12/20/20. The DON confirmed no other interventions were implemented to ensure the safe use of the grab bar on R22's bed.<br><br>Guidance for Industry and FDA Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated 3/10/06, identified the following bed rail zones:<br>Zone 1 - Within the rail, with no more than a 4 and 3/4 inches (in) gap.<br>Zone 2 - Under the rail, between the rail supports or next to a single rail support ,with no more than a 4 and 3/4 in gap.<br>Zone 3 - Between the rail and the mattress, ,with no more than a 4 and 3/4 in gap.<br>Zone 4 - Under the rail at the ends of the rail, ,with no more than a 4 and 3/4 in gap.<br><br>Review of facility incident reports for the past year, did not include any incidents related to unsafe use of siderails.<br><br>Review of R22's treatment administration record (TAR) dated 1/21/21, included a physician's order to check grab bar straps weekly on bed frame | F 700 | risks and benefits of bed rails and the facility will obtain informed consent prior to bed rail installation. Grab bars will be offered as an alternative to bed rails. The facility will follow manufacturer recommendations and specifications for installing and maintaining bed rails and grab bars. Bed rails and grab bars will be checked weekly for stability and will be removed or repaired immediately. Date of Compliance: 2/4/2021.<br><br>Nursing staff has been educated on the bed rail policy (date of compliance: 2/9/2021). Policy has been added to the new employee packet. All employees will be trained on this policy annually. The DON or designee will complete the weekly grab bar/side rail safety check tool. Tool will be audited weekly x 4 weeks to ensure compliance monitoring, then monthly x 2 months, and quarterly x 1. Grab bar and Bed rails have been added to the QAPI agenda. All data/audits and any issues related to grab bars/bed rails will be discussed and amended at monthly QAPI meetings until it is determined that compliance is successful. Date of Compliance: 2/9/2021. | |

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and tighten as needed for security. The TAR indicated registered nurse (RN)-A had just checked R22's grab bar straps for security on 2/1/21 at 1:30 p.m. The surveyor observed the grab bar to be loose at 5:30 p.m.(3 1/2 hours before RN-A had checked it).

During an interview on 2/2/21, at 12:01 p.m. nursing assistant (NA)-A stated R22's bed and grab bar had been in place for a long time. NA-A stated R22's grab bar had been loose since 12/20/20. NA-A thought other staff members who worked with R22 were also aware the grab bar was loose. NA-A stated he had been concerned because R22 would use the grab bar to assist with sitting up in bed and for repositioning. NA-A was concerned R22 could fall or get hurt because the grab bar was loose.

During an interview on 2/2/21, at 12:10 p.m. registered nurse (RN)-B stated she had not been documenting weekly grab bar checks for R22. RN-B stated she would rather randomly check when in R22's room and if she thought the grab bar was loose she would notify maintenance. RN-B stated she had not had to notify maintenance as of yet because she had not identified any concerns.

During an interview on 2/2/21, at 12:14 p.m. RN-A indicated she checked R22's grab bars weekly and would make sure the straps were hooked.

During interview on 2/2/21, at 12:30 p.m. NA-B indicated R22's grab bar had been loose at times for several weeks. NA-B indicated when transferring R22 a few weeks prior, from the bed to the wheelchair, R22 grabbed the grab bar for support and almost fell forward because it was

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loose. NA-B stated she thought she'd reported the incident to the charge nurse but could not remember.

During an interview on 2/3/21, at 2:16 p.m. the DON verified there was no safety assessment completed to ensure the safety of R22's grab bar. The DON indicated when R22 was admitted to the facility in February of 2018, the family had brought in R22's personal bed and attached grab bar to be used. The DON further confirmed the grab bar was attached by straps under the mattress, that tied to the bed frame to hold the grab bar in place.The DON verified R22 had not had any incidents related to the use of the grab bars since admission.The DON also verified there had been no other resident incidents related to the use of grab bars.

Review of the facility's policy Side Rail/Grab Bars dated 1/31/20, indicated the facility is to prevent entrapment and other safety hazards associated with bed rail use. Further, the policy indicated wide spaces between bars in the bed rail can affect the risk of resident entrapment and included: "Space less than 4 ¾ is recommended between a rail and mattress to prevent the risk of head entrapment."

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Central Health Care was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.<br><br>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.<br><br>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.<br><br>"IF OPTING TO USE EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED"<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES<br>( K-TAGS) TO:<br><br>Health Care Fire Inspections | K 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 03/04/2021 |

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 |
|---|---|---|---|
| | 245401 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **02/03/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CENTRAL HEALTH CARE** | **444 NORTH CORDOVA**<br>**LE CENTER, MN 56057** |

| (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 | Continued From page 1<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St Paul, MN 55101-5145, or<br><br>By email to:<br><br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>Central Health Care is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1966 and was determined to be of Type II(111) construction. In 1969, an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. Central Health Care is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1966 and was determined to be of Type II(111) construction. In 1969, an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition | K 000 | | |

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| K 000 | Continued From page 2<br>are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility is divided into two separate smoke compartments.<br><br>The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.<br><br>The facility has a capacity of 44 beds and had a census of 25 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 211 SS=F | Means of Egress - General<br>CFR(s): NFPA 101<br><br>Means of Egress - General<br>Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.<br>18.2.1, 19.2.1, 7.1.10.1<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to comply with NFPA 101 (2012), Life Safety Code, Section 7.1.10.1, which states that all means of egress are to be continuously maintained free of all obstructions to full use in case of emergency. This deficient practice could affect 25 of the 25 residents. | K 211 | K-tag 211 Means of Egress-General<br>CFR(s): NFPA 101<br><br>To ensure the Facility meets the 2021 Life Safety Code the following corrections will be made:<br>The facility will purchase a new push bar | 3/7/21 |

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| K 211 | Continued From page 3<br><br>FINDINGS INCLUDE:<br><br>On facility tour between 10:00 AM and 1:00 PM on 02/03/2021, observation revealed the secondary exit in the East Hallway needs to have the push/panic hardware re-installed on the door.<br><br>This deficient practice was verified by the Facility Maintenance Director. | K 211 | mechanism to be installed on the East Hallway door enabling access out of the building in the event of an emergency. To ensure compliance, The Maintenance Director or designee will perform monthly safety checks to ensure door mechanism is functioning appropriately. To be completed by 3/19/2021. | |
| K 321 SS=E | Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms | K 321 | | 3/7/21 |

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| K 321 | Continued From page 4<br>(exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain hazardous areas by a protected fire barrier having a 1-hour fire-resistance rating per NFPA 101 (2012), Life Safety Code, Section 19.3.2.1.3. The deficient practice could affect 25 out of 25 residents.<br><br>Findings include:<br><br>On facility tour between 10:00 AM and 1:00 PM on 02/03/2021, observation revealed that Resident Room #314 had been converted into a storage room for COVID PPE supplies. This room exceeds 190 square feet and requires a self-closing door that positively latches into the frame upon closing.<br><br>This deficient practice was verified by the Facility Maintenance Director. | K 321 | K-tag 321 Hazardous Areas-Enclosure CFR(s) NFPA 101<br><br>To ensure compliance and safety, the Maintenance Director will install spring loaded hinges to the door of room 314 to meet the requirements of a self-closing door that positively latches into the frame when closing. The Maintenance Director will install a smoke alarm in room 314.<br>The Maintenance Director will perform monthly inspections to ensure the door mechanisms latch into the frame appropriately.<br>The Maintenance Director will perform monthly testing of the smoke alarm to ensure appropriate functioning of the alarm. To be completed by 3/12/2021. | |
| K 781<br>SS=D | Portable Space Heaters<br>CFR(s): NFPA 101<br><br>Portable Space Heaters<br>Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8<br>This REQUIREMENT is not met as evidenced | K 781 | | 3/7/21 |

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| K 781 | Continued From page 5<br>by:<br>Based on documentation review and staff interview, the facility failed to provide a written space heater policy identifying prohibited uses within health care occupancies per NFPA 101 (2012), Life Safety Code, Section 19.7.8. This deficient practice could affect 25 of 25 residents.<br><br>Findings include:<br><br>On facility tour between 10:00 AM and 1:00 PM on 02/03/2021, documentation reviewed revealed that the facility does not have a written space heater policy that is specific to Central Health Care.<br><br>This deficient practice was verified by the Facility Maintenance Director. | K 781 | K-tag 781 Portable Space Heaters<br>CFR(s): NPFA 101<br><br>A written policy specific for facility use of Space Heaters was created on 2/24/2021. Education was provided to staff regarding the restricted use of space heaters in the facility. The Maintenance Director performs monthly safety & cleaning inspections during use.<br>Space Heaters have been removed from the building. Date of Compliance: 2/24/2021. | |