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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UKSF

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

Facility ID: 00296

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245428**

2.STATE VENDOR OR MEDICAID NO.
(L2) **618245301**

3. NAME AND ADDRESS OF FACILITY
(L3) **HOMESTEAD REHABILITATION & LIVING CENTER**
(L4) **115 10TH AVENUE NORTHEAST**
(L5) **DEER RIVER, MN** (L6) **56636**

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 **12/12/2012** (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 IMR | 15 ASC | |
| 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | |

FISCAL YEAR ENDING DATE: (L35)
**12/31**

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IMR |
|---|---|---|---|---|
| | 32 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

**See Attached Remarks**

17. SURVEYOR SIGNATURE Date :
Lyla Burkamn, HFE-NEII 01/14/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 01/14/2013 (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
**02/01/1987**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

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

30. REMARKS
Posted 1/22/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**12/17/2012**
(L33)

DETERMINATION APPROVAL

CCN: 24-5428

Item 16 Continuation for CMS-1539

At the time of the standard survey completed on October 18, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On December 12, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction, and on December 3, 2012 the Minnesota Department of Public Safety completed a PCR and determined that the facility had achieved substantial compliance pursuant to the standard survey completed on October 4, 2012, effective November 27, 2012. Therefore, the remedies outlined in our letter dated November 6, 2012 will not be imposed. See attached CMS-2567B for the results of the December 12, 2012 and December 3, 2012 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Medicare Provider # 24-5428

January 14, 2013

Mr. Jeffry Stampohar, Administrator
Homestead Rehabilitation & Living Center
115 10th Avenue Northeast
Deer River, Minnesota 56636

Dear Mr. Stampohar:

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 November 27, 2012 the above facility is recommended for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 skilled nursing facility beds.

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

Please contact me if you have any questions.

Sincerely,

Nicole Steege

Nicole Steege, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

January 14, 2013

Mr. Jeffry Stampohar, Administrator
Homestead Rehabilitation & Living Center
115 10th Avenue Northeast
Deer River, Minnesota 56636

RE: Project Number S5428022

Dear Mr. Stampohar:

On November 6, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 18, 2012. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 12, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 3, 2012 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 18, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 27, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 18, 2012, effective November 27, 2012 and therefore remedies outlined in our letter to you dated November 6, 2012, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Christy Johnson

Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure

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



| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245428 | A. Building<br>B. Wing | 12/12/2012 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| HOMESTEAD REHABILITATION & LIVING CENTER | 115 10TH AVENUE NORTHEAST<br>DEER RIVER, MN 56636 |

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

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix **F0282**<br>Reg. # **483.20(k)(3)(ii)**<br>LSC | Correction Completed **11/27/2012** | ID Prefix **F0325**<br>Reg. # **483.25(i)**<br>LSC | Correction Completed **11/27/2012** | ID Prefix **F0329**<br>Reg. # **483.25(l)**<br>LSC | Correction Completed **11/27/2012** |
| ID Prefix **F0428**<br>Reg. # **483.60(c)**<br>LSC | Correction Completed **11/27/2012** | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By State Agency | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| | CJ/NCS | 1/14/13 | 28035 | 12/12/12 |
| **Reviewed By CMS RO** | **Reviewed By** | **Date:** | **Signature of Surveyor:** | **Date:** |
| | | | | |

**Followup to Survey Completed on:** 10/18/2012

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

**Post-Certification Revisit Report**



| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245428 | A. Building<br>B. Wing **01 - NURSING HOME** | 12/3/2012 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| HOMESTEAD REHABILITATION & LIVING CENTER | 115 10TH AVENUE NORTHEAST<br>DEER RIVER, MN 56636 |

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

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix | Correction Completed **10/18/2012** | ID Prefix | Correction Completed **10/18/2012** | ID Prefix | Correction Completed **10/18/2012** |
| Reg. # **NFPA 101** | | Reg. # **NFPA 101** | | Reg. # **NFPA 101** | |
| LSC K0011 | | LSC K0025 | | LSC K0029 | |
| ID Prefix | Correction Completed **11/27/2012** | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. # **NFPA 101** | | Reg. # | | Reg. # | |
| LSC K0046 | | LSC | | LSC | |
| ID Prefix | Correction Completed | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. # | | Reg. # | | Reg. # | |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction Completed | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. # | | Reg. # | | Reg. # | |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction Completed | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. # | | Reg. # | | Reg. # | |
| LSC | | LSC | | LSC | |

| | | | | |
|---|---|---|---|---|
| **Reviewed By** _____ **State Agency** | **Reviewed By** PS/NCS | **Date:** 1/14/13 | **Signature of Surveyor:** 03006 | **Date:** 12/3/12 |
| **Reviewed By** _____ **CMS RO** | **Reviewed By** | **Date:** | **Signature of Surveyor:** | **Date:** |

| | | |
|---|---|---|
| **Followup to Survey Completed on:** 10/17/2012 | _____ | **Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO** |

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

January 14, 2013

Mr. Jeffry Stampohar, Administrator
Homestead Rehabilitation & Living Center
115 10th Avenue Northeast
Deer River, Minnesota 56636

Re: Enclosed Reinspection Results - Project Number S5428022

Dear Mr. Stampohar:

On December 12, 2012 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 18, 2012. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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,

Christy Johnson

Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File

# State Form: Revisit Report

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 00296 | A. Building<br>B. Wing | 12/12/2012 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| HOMESTEAD REHABILITATION & LIVING CENTER | 115 10TH AVENUE NORTHEAST<br>DEER RIVER, MN 56636 |

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 **20565**<br>Reg. # **MN Rule 4658.0405 Subp. 3**<br>LSC | Correction Completed **11/27/2012** | ID Prefix **20965**<br>Reg. # **MN Rule 4658.0600 Subp. 2**<br>LSC | Correction Completed **11/27/2012** | ID Prefix **21530**<br>Reg. # **MN Rule 4658.1310 A.B.C**<br>LSC | Correction Completed **11/27/2012** |
| ID Prefix **21535**<br>Reg. # **MN Rule4658.1315 Subp.1 AB(**<br>LSC | Correction Completed **11/27/2012** | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
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| | | | | |
|---|---|---|---|---|
| **Reviewed By** _____<br>**State Agency** | **Reviewed By**<br>CJ/NCS | **Date:**<br>1/14/13 | **Signature of Surveyor:**<br>28035 | **Date:**<br>12/12/12 |
| **Reviewed By** _____<br>**CMS RO** | **Reviewed By** | **Date:** | **Signature of Surveyor:** | **Date:** |

**Followup to Survey Completed on:** 10/18/2012

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

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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UKSF

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

Facility ID: 00296

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245428**
2.STATE VENDOR OR MEDICAID NO.
(L2) **618245301**

3. NAME AND ADDRESS OF FACILITY
(L3) **HOMESTEAD REHABILITATION & LIVING CENTER**
(L4) **115 10TH AVENUE NORTHEAST**
(L5) **DEER RIVER, MN** (L6) **56636**

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 **10/18/2012** (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 IMR | 15 ASC | |
| 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | |

FISCAL YEAR ENDING DATE: (L35)
**12/31**

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

**X** B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IMR |
|---|---|---|---|---|
| | 32 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

**See Attached Remarks**

17. SURVEYOR SIGNATURE Date :
Jane Aandal, HFE-NEII 11/30/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 12/14/2012 (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
**02/01/1987**
(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
(L33)

DETERMINATION APPROVAL

Page 2
Provider Number: 24-5428
Item 16 Continuation for CMS-1539

At the time of the standard survey completed on October 18, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit after November 27, 2012.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7011 2000 0002 5148 9752

November 6, 2012

Mr. Jeffry Stampohar, Administrator
Homestead Rehabilitation & Living Center
115 10th Avenue Northeast
Deer River, Minnesota 56636

RE: Project Number S5428022

Dear Mr. Stampohar:

On October 18, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

**DEPARTMENT CONTACT**

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

Christy Johnson
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933

Telephone: (218) 308-2114

Fax: (218) 308-2122

**OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 27, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by November 27, 2012 the following remedy will be imposed:

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

**PLAN OF CORRECTION (PoC)**

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include signature of provider and date.

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

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

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

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

**PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

### Original deficiencies not corrected

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

### Original deficiencies not corrected and new deficiencies found during the revisit

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

### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 18, 2013 (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 April 18, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**INFORMAL DISPUTE RESOLUTION**

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

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

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

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

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

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

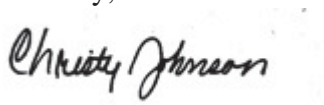
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245428 | A. BUILDING _____ B. WING _____ | 10/18/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOMESTEAD REHABILITATION & LIVING CENTER | 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636 |

| (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<br><br>THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<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. | F 000 | | |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide extra calories and proteins at breakfast and a nutritional supplement (magic cup) every day as directed by the plan of care (POC) for 1 of 3 residents (R33) reviewed who required nutritional supplements.<br><br>Findings include:<br><br>R33 had diagnoses including dementia. The admission Minimum Data Set (MDS) dated 6/28/12, identified the resident with severe | F 282 | **F282**<br><br>Resident 33 passed away on 10/18/12<br><br>The RD and nursing staff identify residents at risk of needing added nutritional supplements. The Plan of Care of residents receiving nutritional supplements and snacks are reviewed and updated as needed. Resident records are reviewed for orders that have not been transcribed/added to the plan of care.<br><br>A daily review of charts for new order | |

2 addenda
11-30-12

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Jeffrey Stigen | CEO | 11/12/2012 |

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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| F 282 | Continued From page 1<br>cognitive impairment and as being totally dependent on staff for all activities of daily living including eating.<br><br>The POC updated 7/16/12, indicated R33 had a need for extra calories and protein at mealtime. The plan of care updated 9/27/12, directed staff to administer a nutritional supplement every day per physician orders.<br><br>A dietary progress note from the registered dietician (RD) dated 9/4/12, noted R33 was preferring to sleep late and not eating breakfast. The note indicated the kitchen would serve a late breakfast. A review of the resident daily intake record identified R33 did not eat any breakfast after 9/4/12.<br><br>On 10/17/12, at 11:30 a.m. nursing assistant (NA) -D stated R33's normal routine was to get up at 10:30 a.m. and then have thickened juice, milk, or water, and maybe some applesauce. NA-D added that would "do him until lunch time."<br><br>The physician's orders dated 9/27/12, included a nutritional supplement every day at 3:00 p.m. per dietician recommendation due to weight loss. However, the physician order for nutritional supplement was not transcribed to the medication administration record (MAR) and the record lacked documentation R33 received the supplement.<br><br>On 10/16/12, at 8:11 a.m. registered nurse (RN) -A stated R33 did receive a nutritional supplement (magic cup) every day.<br><br>On 10/17/12, at 11:35 a.m. RN-A reviewed the | F 282 | transcription has been implemented. Any order found not to have been transcribed is transcribed upon discovery.<br>A new method of documentation that includes the amount of the snack or supplement consumed has been implemented. Nursing staff will review and summarize consumption weekly, Nursing and dietary staff have been educated on the new process.<br>The RD will review Snack and Supplement consumption record bimonthly and make recommendations on an as needed basis.<br>The Snack and Supplement Policy and Procedure has been updated.<br><br>The DON/designee will review the documentation of nutritional supplements and snack on a daily basis for one week, weekly times four, monthly times 3, and quarterly times four. Variances will be reported to QA at least quarterly.<br><br>Implementation of the plan will be completed by November 27, 2012. | |

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|---|---|---|---|---|
| F 282 | Continued From page 2<br>MAR and stated the physician's order for the supplement did not get transcribed to the MAR, therefore, it was never signed off by the licensed practical nurse (LPN) and there was no documentation the supplement was given.<br><br>On 10/17/12, at 11:10 a.m. LPN-A was interviewed and stated she was not aware R33 was to receive a supplement. LPN-A added if it was not in the MAR, she would have no way of knowing it was her responsibility to monitor if or how much R33 consumed the supplement,<br><br>On 10/17/12, at 3:30 p.m. NA-B stated she had never given R33 a magic cup supplement and was not aware he had an order for one.<br><br>On 10/17/12, at 3:45 p.m. LPN-B also stated she was not aware R33 had an order for a nutritional supplement.<br><br>On 10/17/12, at 1:30 p.m. the RD verified she was aware he had been eating only 2 meals a day since the beginning of September. She verified if he was not eating breakfast he was not getting the supper cereal or extra calories with the butter and juice. The RD stated the kitchen staff was delivering the supplement, but the medical record indicated R33 had not received the supplement as ordered because nursing had not transcribed the order to the MAR.<br><br>On 10/18/12, at 8:13 a.m. the director of nursing (DON) stated R33's supplement (magic cup) was not being given according to the plan of care. The DON stated the physician's order was mistakenly not transcribed. | F 282 | | |

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|---|---|---|---|---|
| F 282 | Continued From page 3<br>The Snacks and Supplement policy and procedure dated 12/2005, indicated the Long Term Care Facility would provide snacks and nutritional supplements for residents who request or require them. The policy noted nursing staff will deliver the nutritional supplements to the residents and will record the amount consumed in the medical record. | F 282 | | |
| F 325 SS=D | 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE<br><br>Based on a resident's comprehensive assessment, the facility must ensure that a resident -<br>(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<br>(2) Receives a therapeutic diet when there is a nutritional problem.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to monitor the effectiveness of nutritional interventions and failed to implement nutritional supplements to try improve nutritional status and minimize further weight loss for 1 of 3 residents (R33) in the sample who had been identified with weight loss.<br><br>Findings include:<br><br>R33 was admitted on 6/17/12, with diagnoses | F 325 | **F325**<br><br>Resident 33 passed away on 10/18/12.<br><br>The RD and nursing staff have identify residents at risk of needing added nutritional supplements. The Plan of Care of residents receiving nutritional supplements and snacks has been reviewed and updated as needed. Resident records have been reviewed for orders that have not been transcribed/added to the plan of care.<br><br>A daily review of charts for new order transcription has been implemented. Any order found not to have been transcribed is transcribed upon discovery.<br>A new method of documentation that includes the amount of the snack or supplement consumed has been implemented. Nursing staff will review and summarize consumption weekly, Nursing and dietary staff have been educated on the new process. | |

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|---|---|---|---|---|
| F 325 | Continued From page 4<br>including dementia, congestive heart failure, and coronary artery disease. The admission Minimum Data Set (MDS) dated 6/28/12, identified R33 with severe cognitive impairment and as being totally dependent on staff for all activities of daily living including eating. The MDS identified R33 as 70 inches tall, 193 pounds, and utilizing a mechanically altered diet. The Nutritional Status Care Area Assessment (CAA) dated 7/2/12, indicated R33's appetite was declining and often refused fluids and food. The CAA also indicated the physician and family were informed of the nutritional decline and wanted no intravenous feedings or feeding tube. The change of status MDS dated 9/28/12, identified R33 had experienced a significant weight loss (a 5% or more weight loss in last 30 days) with a weight of 178 pounds.<br><br>The Nutritional Assessment completed by the registered dietician (RD) dated 6/21/12, identified R33 as being at "moderate nutritional risk. " The assessment indicated R33 received a regular diet, was able to feed himself, and ate 75% of foods at most meals. The assessment also indicated a past/usual body weight of 185 - 203 pounds. A dietary progress note from the RD dated 7/23/12, noted R33 had a 8.3 pound weight loss and was supportive care. The note indicated R33 had a possible cerebral vascular accident (CVA/stroke) and was evaluated by occupational therapy on 6/29/12. The recommendation was to provide a pureed diet and thickened fluids. The note also indicated R33 now required complete assistance with meals, and intake was now greater than 75%, 2 meals a day and 240-740 cc of fluid each day. The plan was to add extra calories at meals and consider adding | F 325 | The RD will review Snack and Supplement consumption record bimonthly and make recommendations on an as needed basis.<br>The Snack and Supplement Policy and Procedure has been updated.<br><br>The DON/designee will review the documentation of nutritional supplements and snack on a daily basis for one week, weekly times four, monthly times 3, and quarterly times four. Variances will be reported to QA at least quarterly.<br><br>Implementation of the plan will be completed by November 27, 2012. | |

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| F 325 | Continued From page 5<br>supplements if weight loss continued.<br><br>The plan of care updated 7/16/12, indicated R33 had a need for extra calories, protein, and fluids at mealtime. The plan of care updated 9/27/12, directed staff to administer a nutritional supplement every day per physician orders. A review of R33's meal ticket (which told the cook what to serve) identified extra calories were provided by extra butter, supper cereal at breakfast, yogurt, and juice. However the medical record lacked documentation of how much of the extra calories R33 actually consumed.<br><br>A dietary progress note from the RD dated 9/4/12, noted R33 was preferring to sleep late and not eating breakfast. The note indicated the kitchen would serve a late breakfast. A review of the resident daily intake record identified R33 did not eat any breakfast after 9/4/12.<br><br>On 10/17/12, at 11:30 a.m. NA-D stated R33's normal routine was to get up at 10:30 a.m. and then have thickened juice, milk, or water, and maybe some applesauce. NA-D added that would "do him until lunch time."<br><br>The quarterly nutrition review dated 9/27/12, identified R33's weight as 177.9 (15.5 weight loss since admit 3 months ago) and that R33 was at nutritional risk due to dementia, impaired swallowing, weight loss, and medication changes. The recommendation was to add a nutritional supplement and continue to encourage intake at meals.<br><br>The physician's orders dated 9/27/12, included a | F 325 | | |

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|---|---|---|---|---|
| F 325 | Continued From page 6<br>nutritional supplement every day at 3:00 p.m. per dietician recommendation due to weight loss. However, the physician order for nutritional supplement was not transcribed to the medication administration record (MAR) and the record lacked documentation R33 ever received the supplement.<br><br>On 10/15/12, at 6:15 p.m. R33 was observed sitting in a reclining chair in the dining room. R33 refused to eat or drink with eyes remaining closed.<br><br>On 10/17/12, at 9:00 a.m. R33 was observed in bed, resting quietly and did not respond to speech or touch. The medical record indicated R33 passed away the morning of 10/18/12.<br><br>R33's weight record indicated:<br><br>On 6/18/12, R33 weighed 193 pounds.<br>On 7/4/12, R33 weighed 185 pounds.<br>On 8/3/12, R33 weighed 181 pounds.<br>On 9/3/12, R33 weighed 178 pounds.<br>On 10/3/12, R33 weighed 165 pounds.<br><br>On 10/16/12, at 8:11 a.m. registered nurse (RN) -A stated R33 received a nutritional supplement (magic cup) every day.<br><br>On 10/17/12, at 11:35 a.m. RN-A reviewed the MAR and stated the physician's order for the supplement did not get transcribed to the MAR. Therefore it was never signed off by the licensed practical nurse (LPN) and there was no documentation the supplement was given.<br><br>On 10/17/12, at 11:10 a.m. LPN-A stated she was | F 325 | | |

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| F 325 | Continued From page 7<br>not aware R33 was to receive a supplement. LPN-A added if it was not in the MAR, she would have no way of knowing it was her responsibility to monitor if the supplement was given or how much R33 consumed.<br><br>On 10/17/12, at 3:30 p.m. nursing assistant (NA) -B stated she had never given R33 a magic cup supplement and was not aware he had an order for one.<br><br>On 10/17/12, at 3:45 p.m. LPN-B also stated she was not aware R33 had an order for a nutritional supplement.<br><br>On 10/17/12, at 1:30 p.m. the RD explained she had added extra calories at meal times when she first became aware of the weight loss, which was 7/23/12. The RD stated there was no way to monitor if R33 actually received the extra calories because the facility monitors just the percentage of meal consumed not the actual extra calories. The RD verified R33 had a significant weight loss, had been eating only 2 meals a day since the beginning of September, and if he was not eating breakfast he was not getting the supper cereal or extra calories with the butter and juice. The RD stated she recommended giving the supplement at 3:00 p.m. since he was not eating much at meals. The RD stated the kitchen staff was delivering the supplement, but the medical record indicated R33 had not received the supplement as ordered because nursing had not transcribed the order to the MAR.<br><br>On 10/18/12, at 8:13 a.m. the director of nursing (DON) stated there was a communication problem and R33's supplement (magic cup) was | F 325 | | |

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| F 325 | Continued From page 8<br>not being given according to the physician's order because it was not transcribed. The DON also stated she was not sure how effective the extra calories were since they were given with meals and there was no way to monitor how much "extra calories" were actually consumed. The DON stated other interventions could have been implemented sooner.<br><br>The Snacks and Supplement policy and procedure dated 12/2005, indicated the Long Term Care Facility would provide snacks and nutritional supplements for residents who request or require them. The policy noted nursing staff will deliver the nutritional supplements to the residents and will record the amount consumed in the medical record. | F 325 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>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.<br><br>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 | F 329 | **F329**<br><br>The use of the antidepressant for Resident 20 has been reviewed by the consulting pharmacist, the medical director and the QA committee. The Medical Director is reviewing the risk /benefit with the physician. The Medical Director has indicated that the physician is reviewing the case and will make further recommendations.<br><br>The consulting pharmacist reviews and recommends medication | |

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|---|---|
| HOMESTEAD REHABILITATION & LIVING CENTER | 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636 |

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| F 329 | Continued From page 9<br>behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to attempt to taper an antidepressant medication and the record lacked documentation of clinical rationale as to why this would be contraindicated for 1 of 5 residents (R20) reviewed that received an antidepressant.<br><br>Findings include:<br><br>R20 had received the same dosage of Lexapro and Remeron (antidepressant medications) since 9/19/10, without the facility attempting a tapering to determine if the resident's symptoms could be controlled on a lower dosage or eliminated altogether.<br><br>R20 had diagnoses including cerebral vascular accident, seizures, and depression. The annual Minimum Data Set (MDS) dated 8/30/12, indicated R20 had mild cognitive impairment, complained of feeling tired or having no energy nearly every day, and had one symptom of feeling depressed within the last 14 days.<br><br>The current physician's order dated 8/28/12, indicated R20 was receiving Lexapro 10 mg every day and Remeron 7.5 mg every night. | F 329 | changes on a monthly basis for all residents. The reports are forwarded to the physician for action. The procedure for reviewing physician recommendations has been modified, the DON will review the recommendation after the physician has reviewed the recommendation of the pharmacist. Nursing staff implement the recommendations of the physician.<br><br>The Director of Nursing has met with the medical director. The policy has been reviewed and updated. The system for ensuring reviews are acted upon in a timely manner has been updated.<br>The Medical Director and DON educated the physicians and nurses on accurate risk benefit statements.<br><br>The DON will review all recommendations returned by physicians for three months. The quality assurance committee will randomly review records of residents receiving psychotropic medications quarterly.<br><br>Implementation of the plan will be completed by November 27, 2012. | |

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| F 329 | Continued From page 10<br>The consultant pharmacist's review dated 5/22/12, noted R20 had been on Lexapro and Remeron since 9/2010, without an attempt to decrease or taper. The pharmacist's suggested course of action was for the physician to determine if these medications could be tapered down or to provide a risk/benefit statement.<br><br>The medical record indicated on 8/20/12, the physician documented on the pharmacist's review form, "Patient is on very low doses of both medications. Mood is good. Patient has more benefit by staying on these medications." However, the documentation lacked clinical rationale as to why an attempt to taper these medications was contraindicated. A review of the medical progress note for a routine nursing home visit dated 9/2/12, identified R20 as very pleasant elderly female, sitting in her bed with no acute distress.<br><br>On 10/18/12, at 10:10 a.m. the director of nursing (DON) stated the physician did not want any changes in the medication. The DON stated R20 had been on the same dose since 9/2010 and there had never been an attempt at tapering to determine if tapering would be effective. The DON stated this had been addressed with the physician, but the physician chose not to make any changes.<br><br>The Medication Management policy with a review date of 7/23/2007, noted after the facility had initiated a psychopharmacological medication (other than an antipsychotic or a sedative/hypnotic), the facility attempts a gradual dose reduction during at least two separate | F 329 | | |

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| F 329 | Continued From page 11<br>quarters unless clinically contrainindicated. After the first year, a tapering should be attempted annually unless clinically contrainindicated. The continued use in accordance with relevant current standard of practice and the physician documents the clinical rationale for why and additional attempted dose reductions would likely impair the resident's function, increase distressed behavior or cause psychiatric instability. | F 329 | | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure the physician and the director of nursing acted upon the pharmacy recommendation for 1 of 8 residents (R20) in the sample reviewed with pharmacy recommendations.<br><br>Findings include:<br><br>R20's current physician's order dated 8/28/12, indicated R20 was receiving Lexapro 10 mg every day and Remeron 7.5 mg every night | F 428 | **F428**<br><br>The use of the antidepressant for Resident 20 has been reviewed by the consulting pharmacist, the medical director and the QA committee. The Medical Director has reviewed the need for a risk /benefit statement with the physician. The Medical Director has indicated that the physician is reviewing the case and will make further recommendations.<br><br>The consulting pharmacist reviews and recommends medication changes on a monthly basis for all residents. The reports are forwarded to the physician for action. The procedure for reviewing physician recommendations has been modified, the DON will review the recommendation after the physician | |

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| F 428 | Continued From page 12<br><br>The consultant pharmacist's review dated 5/22/12, noted R20 had been on Lexapro and Remeron since 9/2010, without an attempt to decrease or taper. The pharmacist's suggested course of action was for the physician to determine if these medications could be tapered down or to provide a risk/benefit statement.<br><br>The medical record indicated on 8/20/12, the physician documented on the pharmacist's review form, "Patient is on very low doses of both medications. Mood is good. Patient has more benefit by staying on these medications." However, the documentation lacked clinical rationale as to why an attempt to taper these medications was contraindicated. A review of the medical progress note for a routine nursing home visit dated 9/2/12, identified R20 as a very pleasant elderly female, sitting in her bed with no acute distress.<br><br>On 10/18/12, at 10:10 a.m. the director of nursing (DON) stated the physician did not want any changes in the medication. The DON stated R20 had been on the same dose since 9/2010, and there had never been an attempt at tapering the medications. The DON stated this had been addressed with the physician, but the physician chose not to make any changes.<br><br>The facility policy of Monthly Medication Regime Review with a review date of 7/23/2007, noted the consulting pharmacist reviews the medication regime monthly and identifies irregularities. The recommendations are reported to the director of nursing and the prescriber. The physician | F 428 | has reviewed the recommendation of the pharmacist. Nursing staff implement the recommendations of the physician.<br><br>The Director of Nursing has met with the medical director. The policy has been reviewed and updated. The system for ensuring reviews are acted upon in a timely manner has been updated.<br>The Medical Director and DON educated the physicians and nursing staff on accurate risk benefit statements and the guidelines for reducing/omitting unnecessary drugs.<br><br>The DON will review all recommendations returned by physicians for three months. I The quality assurance committee will randomly review records of residents receiving psychotropic medications quarterly.<br><br>Implementation of the plan will be completed by November 27, 2012. | |

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| F 428 | Continued From page 13<br>accepts and acts upon suggestions or rejects and provides an explanation for disagreeing. | F 428 | | |

Deer River
HealthCare Center
Quality, Compassionate HealthCare for Life

**F329**

The use of the antidepressant for Resident 20 has been reviewed by the consulting pharmacist, the medical director and the QA committee. The Medical Director is reviewing the risk /benefit with the physician. The Medical Director has indicated that the physician is reviewing the case and will make further recommendations. Effective 11/27/2012:The physician has recommended a dose change for the resident.

The records of all residents on psychotropics has been audited. Other residents needing reductions have been identified and the physician has been notified of this need.

The consulting pharmacist reviews and recommends medication changes on a monthly basis for all residents. The reports are forwarded to the physician for action. The procedure for reviewing physician recommendations has been modified, the DON will review the recommendation after the physician has reviewed the recommendation of the pharmacist. Nursing staff implement the recommendations of the physician.

The Director of Nursing has met with the medical director. The policy has been reviewed and updated. The system for ensuring reviews are acted upon in a timely manner has been updated. An audit method of monitoring residents on psychotropics and schedule for attempts of reduction has been developed. The Medical Director and DON educated the physicians and nurses on accurate risk benefit statements.

The DON will review all recommendations returned by physician's times three months. The quality assurance committee will randomly review records of residents receiving psychotropic medications quarterly.

Implementation of the plan will be completed by November 27, 2012.

K. Strealas
11/30/12

Deer River
HealthCare Center
Quality, Compassionate HealthCare for Life

Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
705 5th St. NW, Suite A
Bemidji MN 56601-2933

Dear Christy:

The following document is the addendum to the correction plan for Homestead Rehabilitation and Living Center, Deer River, MN. I have highlighted the additions to the original plan of correction.

If you have any questions, please do not hesitate to call me.

Sincerely,
Karen Skraba, R.N.
Director of Senior Services
Essentia Health-Homestead Karen Skraba
11/30/12

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<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 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>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Homestead Rehabilitation and Living Center 01 Main Building was found 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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota Street, Suite 145<br>St. Paul, MN 55101<br><br>Or by e-mail to: | K 000 |  <br>POC rt<br>PR 11-26-12 | |

DC: 11.27.2012

EXIT: 10.18.2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 11-16-2012

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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| K 000 | Continued From page 1<br>Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us<br><br>Fax Number 651-215-0525<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>Homestead Rehabilitation and Living Center is a 1-story building without a basement that is attached to a hospital. The building was constructed in 2 major stages. The original building was constructed in 1973, was determined to be of Type II(111) construction. In 1990 an addition to the north of the building was constructed and was determined to be of a Type II(111) construction. The hospital is separated from the nursing home building with two hour fire barriers and was not inspected at this time. The building is divided into 2 smoke zones.<br><br>The building is completely sprinkler protected with an automatic fire sprinkler system that is installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition) with quick response heads, except as noted in K56. The facility has a fire alarm system with smoke detection throughout the corridor system, | K 000 | | |

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| K 000 | Continued From page 2<br>in spaces open to the corridors and in all sleeping rooms that is monitored for automatic fire department notification installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). Other hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition)<br><br>The facility has a capacity of 32 beds and had a census of 30 at the time of the survey.<br><br>Because the original building and its additions meet the construction type allowed for existing buildings the facility was surveyed as a single building.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 011 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2<br><br>This STANDARD is not met as evidenced by:<br>Observations revealed that one of two fire rated barriers between the hospital and the living center is not in accordance with NFPA 101 "The Life Safety Code" (2000 edition) section 19.1.1.4.1. This deficient practice could negatively affect all | K 011 | **K11**<br><br>The latch on the 1 ½ hour fire door in the 2 hour fire barrier between the living center and the hospital was resolved on October 17, 2012.<br><br>18<br>B | |

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| K 011 | Continued From page 3<br>of the residents, staff and visitors in the event of a fire by allowing fire and smoke to pass from one building to the other.<br><br>Findings include:<br>Observations during the facility tour on October 17, 2012, between 9:45 am and 11:00 am, revealed that the 1 1/2 hour fire door in the west 2-hour fire barrier between the living center and the hospital did not latch when released an allowed to become self-closing.<br><br>The Director of Maintenance (MC) and MDH Engineer (BD) verified this finding during the inspection and at the exit conference. | K 011 | | |
| K 025<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4<br><br>This STANDARD is not met as evidenced by:<br>Observations revealed that one of one smoke barriers is not in accordance with NFPA 101 "The Life Safety Code" (2000 edition) section 19.3.7.3. This deficient practice could negatively affect all of the residents, staff and visitors of the wings | K 025 | **K25**<br><br>The east wing smoke barrier unsealed wire conduit was repaired on October ~~17~~ 18, 2012. | |

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| K 025 | Continued From page 4<br>effected in the event of a fire by allowing fire and smoke to pass from one side of the barrier to the other.<br><br>Findings include:<br>Observations during the facility tour on October 17, 2012, between 9:45 am and 11:00 am, revealed that the east wing smoke barrier has an unsealed wire conduit sleeve through the barrier above the ceiling in the corridor on the north side of the barrier.<br><br>The Director of Maintenance (MC) and MDH Engineer (BD) verified this finding during the inspection and at the exit conference. | K 025 | | |
| K 029<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br><br>This STANDARD is not met as evidenced by:<br>Observations revealed that at least two resident rooms are now being used as storage rooms and are not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.2.1. This deficient practice could allow the products of | K 029 | **K29**<br><br>The 20 minute door on the storage room 127 with a ¾ hour fire door was replaced on October ~~17~~ 18, 2012 | |

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| K 029 | Continued From page 5<br>combustion to travel from one area to another if a fire occurs within this hazardous area, which could negatively impact all patients, visitors and staff.<br><br>Findings include:<br>Observations during the facility tour on October 17, 2012, between 9:45 am and 11:00 am, revealed that the corridor door to storage room 127 is labeled 20 minute and is required to be 3/4 hour fire rated.<br><br>The Director of Maintenance (MC) and MDH Engineer (BD) verified this finding during the inspection and at the exit conference. | K 029 | | |
| K 046 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.<br><br>This STANDARD is not met as evidenced by:<br>Observations and an interview with facility staff revealed that middle exit discharge is not illuminated the as required by NFPA 101 "The Life Safety Code" (2000 edition) section 7.8.1.3. This deficient practice could affect quick, efficient and safe relocation of all residents and staff in the event of a power failure and a failure of the emergency generator.<br><br>Findings include:<br>Observations during the facility tour on October 17, 2012, between 9:45 am and 11:00 am, revealed that the exterior exit discharge for the middle, across from the nurse's station is not illuminated. | K 046 | **K046**<br><br>The exit discharge light for the middle exit has been ordered. Light will be replaced on or before November 27, 2012. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245428 | A. BUILDING 01 - NURSING HOME<br>B. WING _____ | 10/17/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOMESTEAD REHABILITATION & LIVING CENTER | 115 10TH AVENUE NORTHEAST<br>DEER RIVER, MN 56636 |

| (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 |
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| K 046 | Continued From page 6<br><br>The Director of Maintenance (MC) and MDH Engineer (BD) verified this finding during the inspection and at the exit conference. | K 046 | | |

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7011 2000 0002 5148 9752

November 6, 2012

Mr. Jeffry Stampohar, Administrator
Homestead Rehabilitation & Living Center
115 10th Avenue Northeast
Deer River, Minnesota 56636

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5428022

Dear Mr. Stampohar:

The above facility was surveyed on October 15, 2012 through October 18, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

and the Time Period For Correction.

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

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

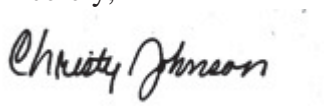
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 705 5th Street NW, Suite A, Bemidji, Minnesota 56601-2933. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance 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,



Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114  Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00296 | A. BUILDING _____ B. WING _____ | 10/18/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOMESTEAD REHABILITATION & LIVING CEN | 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636 |

| (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 |
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| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On October 15, 16, 17, & 18, 2012, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and | 2 000 | 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. | |



**Not Signed**

TITLE (X6) DATE

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00296 | A. BUILDING _____ B. WING _____ | 10/18/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 2 000 | Continued From page 1<br>Certification Program; 705 5th St. N.W., Suite A, Bemidji, MN 56601-2933 | 2 000 | 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 which 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | |
| 2 565 | MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use<br><br>Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. | 2 565 | | |

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|---|---|---|---|---|
| 2 565 | Continued From page 2<br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide extra calories and proteins at breakfast and a nutritional supplement (magic cup) every day as directed by the plan of care (POC) for 1 of 3 residents (R33) reviewed who required nutritional supplements.<br><br>Findings include:<br><br>R33 had diagnoses including dementia. The admission Minimum Data Set (MDS) dated 6/28/12, identified the resident with severe cognitive impairment and as being totally dependent on staff for all activities of daily living including eating.<br><br>The POC updated 7/16/12, indicated R33 had a need for extra calories and protein at mealtime. The plan of care updated 9/27/12, directed staff to administer a nutritional supplement every day per physician orders.<br><br>A dietary progress note from the registered dietician (RD) dated 9/4/12, noted R33 was preferring to sleep late and not eating breakfast. The note indicated the kitchen would serve a late breakfast. A review of the resident daily intake record identified R33 did not eat any breakfast after 9/4/12.<br><br>On 10/17/12, at 11:30 a.m. nursing assistant (NA) -D stated R33's normal routine was to get up at 10:30 a.m. and then have thickened juice, milk, or water, and maybe some applesauce. NA-D added that would "do him until lunch time."<br><br>The physician's orders dated 9/27/12, included a nutritional supplement every day at 3:00 p.m. per | 2 565 | | |

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| HOMESTEAD REHABILITATION & LIVING CEN | 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636 |

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| 2 565 | Continued From page 3<br>dietician recommendation due to weight loss. However, the physician order for nutritional supplement was not transcribed to the medication administration record (MAR) and the record lacked documentation R33 received the supplement.<br><br>On 10/16/12, at 8:11 a.m. registered nurse (RN) -A stated R33 did receive a nutritional supplement (magic cup) every day.<br><br>On 10/17/12, at 11:35 a.m. RN-A reviewed the MAR and stated the physician's order for the supplement did not get transcribed to the MAR, therefore, it was never signed off by the licensed practical nurse (LPN) and there was no documentation the supplement was given.<br><br>On 10/17/12, at 11:10 a.m. LPN-A was interviewed and stated she was not aware R33 was to receive a supplement. LPN-A added if it was not in the MAR, she would have no way of knowing it was her responsibility to monitor if or how much R33 consumed the supplement,<br><br>On 10/17/12, at 3:30 p.m. NA-B stated she had never given R33 a magic cup supplement and was not aware he had an order for one.<br><br>On 10/17/12, at 3:45 p.m. LPN-B also stated she was not aware R33 had an order for a nutritional supplement.<br><br>On 10/17/12, at 1:30 p.m. the RD verified she was aware he had been eating only 2 meals a day since the beginning of September. She verified if he was not eating breakfast he was not getting the supper cereal or extra calories with the butter and juice. The RD stated the kitchen staff was delivering the supplement, but the | 2 565 | | |

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| 2 565 | Continued From page 4<br>medical record indicated R33 had not received the supplement as ordered because nursing had not transcribed the order to the MAR.<br><br>On 10/18/12, at 8:13 a.m. the director of nursing (DON) stated R33's supplement (magic cup) was not being given according to the plan of care. The DON stated the physician's order was mistakenly not transcribed.<br><br>The Snacks and Supplement policy and procedure dated 12/2005, indicated the Long Term Care Facility would provide snacks and nutritional supplements for residents who request or require them. The policy noted nursing staff will deliver the nutritional supplements to the residents and will record the amount consumed in the medical record.<br><br>SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing nutritional supplements as directed by the written plan of care.<br><br>TIME PERIOD FOR CORRECTION: Twenty one (21) days. | 2 565 | | |
| 2 965 | MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status<br><br>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 | 2 965 | | |

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| 2 965 | Continued From page 5<br>must be offered to residents who refuse food served.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to monitor the effectiveness of nutritional interventions and failed to implement nutritional supplements to try improve nutritional status and minimize further weight loss for 1 of 3 residents (R33) in the sample who had been identified with weight loss.<br><br>Findings include:<br><br>R33 was admitted on 6/17/12, with diagnoses including dementia, congestive heart failure, and coronary artery disease. The admission Minimum Data Set (MDS) dated 6/28/12, identified R33 with severe cognitive impairment and as being totally dependent on staff for all activities of daily living including eating. The MDS identified R33 as 70 inches tall, 193 pounds, and utilizing a mechanically altered diet. The Nutritional Status Care Area Assessment (CAA) dated 7/2/12, indicated R33's appetite was declining and often refused fluids and food. The CAA also indicated the physician and family were informed of the nutritional decline and wanted no intravenous feedings or feeding tube. The change of status MDS dated 9/28/12, identified R33 had experienced a significant weight loss (a 5% or more weight loss in last 30 days) with a weight of 178 pounds.<br><br>The Nutritional Assessment completed by the registered dietician (RD) dated 6/21/12, identified | 2 965 | | |

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| 2 965 | Continued From page 6<br><br>R33 as being at "moderate nutritional risk. " The assessment indicated R33 received a regular diet, was able to feed himself, and ate 75% of foods at most meals. The assessment also indicated a past/usual body weight of 185 - 203 pounds. A dietary progress note from the RD dated 7/23/12, noted R33 had a 8.3 pound weight loss and was supportive care. The note indicated R33 had a possible cerebral vascular accident (CVA/stroke) and was evaluated by occupational therapy on 6/29/12. The recommendation was to provide a pureed diet and thickened fluids. The note also indicated R33 now required complete assistance with meals, and intake was now greater than 75%, 2 meals a day and 240-740 cc of fluid each day. The plan was to add extra calories at meals and consider adding supplements if weight loss continued.<br><br>The plan of care updated 7/16/12, indicated R33 had a need for extra calories, protein, and fluids at mealtime. The plan of care updated 9/27/12, directed staff to administer a nutritional supplement every day per physician orders. A review of R33's meal ticket (which told the cook what to serve) identified extra calories were provided by extra butter, supper cereal at breakfast, yogurt, and juice. However the medical record lacked documentation of how much of the extra calories R33 actually consumed.<br><br>A dietary progress note from the RD dated 9/4/12, noted R33 was preferring to sleep late and not eating breakfast. The note indicated the kitchen would serve a late breakfast. A review of the resident daily intake record identified R33 did not eat any breakfast after 9/4/12.<br><br>On 10/17/12, at 11:30 a.m. NA-D stated R33's | 2 965 | | |

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| 2 965 | Continued From page 7<br>normal routine was to get up at 10:30 a.m. and then have thickened juice, milk, or water, and maybe some applesauce. NA-D added that would "do him until lunch time."<br><br>The quarterly nutrition review dated 9/27/12, identified R33's weight as 177.9 (15.5 weight loss since admit 3 months ago) and that R33 was at nutritional risk due to dementia, impaired swallowing, weight loss, and medication changes. The recommendation was to add a nutritional supplement and continue to encourage intake at meals.<br><br>The physician's orders dated 9/27/12, included a nutritional supplement every day at 3:00 p.m. per dietician recommendation due to weight loss. However, the physician order for nutritional supplement was not transcribed to the medication administration record (MAR) and the record lacked documentation R33 ever received the supplement.<br><br>On 10/15/12, at 6:15 p.m. R33 was observed sitting in a reclining chair in the dining room. R33 refused to eat or drink with eyes remaining closed.<br><br>On 10/17/12, at 9:00 a.m. R33 was observed in bed, resting quietly and did not respond to speech or touch. The medical record indicated R33 passed away the morning of 10/18/12.<br><br>R33's weight record indicated:<br><br>On 6/18/12, R33 weighed 193 pounds.<br>On 7/4/12, R33 weighed 185 pounds.<br>On 8/3/12, R33 weighed 181 pounds.<br>On 9/3/12, R33 weighed 178 pounds.<br>On 10/3/12, R33 weighed 165 pounds. | 2 965 | | |

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| 2 965 | Continued From page 8<br><br>On 10/16/12, at 8:11 a.m. registered nurse (RN) -A stated R33 received a nutritional supplement (magic cup) every day.<br><br>On 10/17/12, at 11:35 a.m. RN-A reviewed the MAR and stated the physician's order for the supplement did not get transcribed to the MAR. Therefore it was never signed off by the licensed practical nurse (LPN) and there was no documentation the supplement was given.<br><br>On 10/17/12, at 11:10 a.m. LPN-A stated she was not aware R33 was to receive a supplement. LPN-A added if it was not in the MAR, she would have no way of knowing it was her responsibility to monitor if the supplement was given or how much R33 consumed.<br><br>On 10/17/12, at 3:30 p.m. nursing assistant (NA) -B stated she had never given R33 a magic cup supplement and was not aware he had an order for one.<br><br>On 10/17/12, at 3:45 p.m. LPN-B also stated she was not aware R33 had an order for a nutritional supplement.<br><br>On 10/17/12, at 1:30 p.m. the RD explained she had added extra calories at meal times when she first became aware of the weight loss, which was 7/23/12. The RD stated there was no way to monitor if R33 actually received the extra calories because the facility monitors just the percentage of meal consumed not the actual extra calories. The RD verified R33 had a significant weight loss, had been eating only 2 meals a day since the beginning of September, and if he was not eating breakfast he was not getting the supper cereal or extra calories with the butter and juice. The RD | 2 965 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 2 965 | Continued From page 9<br><br>stated she recommended giving the supplement at 3:00 p.m. since he was not eating much at meals. The RD stated the kitchen staff was delivering the supplement, but the medical record indicated R33 had not received the supplement as ordered because nursing had not transcribed the order to the MAR.<br><br>On 10/18/12, at 8:13 a.m. the director of nursing (DON) stated there was a communication problem and R33's supplement (magic cup) was not being given according to the physician's order because it was not transcribed. The DON also stated she was not sure how effective the extra calories were since they were given with meals and there was no way to monitor how much "extra calories" were actually consumed. The DON stated other interventions could have been implemented sooner.<br><br>The Snacks and Supplement policy and procedure dated 12/2005, indicated the Long Term Care Facility would provide snacks and nutritional supplements for residents who request or require them. The policy noted nursing staff will deliver the nutritional supplements to the residents and will record the amount consumed in the medical record.<br><br>Suggested Method of Correction: The director of nursing and the dietary manager could review and revise the policy and procedures regarding nutritional supplements. They could provide training for the dietary and nursing staff. The quality assessment and assurance committee could randomly audit records of residents identified as receiving nutritional supplements. | 2 965 | | |

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| | 00296 | A. BUILDING _____ B. WING _____ | 10/18/2012 |

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| HOMESTEAD REHABILITATION & LIVING CEN | 115 10TH AVENUE NORTHEAST DEER RIVER, MN 56636 |

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| 2 965 | Continued From page 10<br>Time Period for Correction: Twenty-one (21) days. | 2 965 | | |
| 21530 | MN Rule 4658.1310 A.B.C Drug Regimen Review<br><br>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 system. It is not subject to frequent change.<br>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.<br>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 | 21530 | | |

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| 21530 | Continued From page 11<br>the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure the physician and the director of nursing acted upon the pharmacy recommendation for 1 of 8 residents (R20) in the sample reviewed with pharmacy recommendations.<br><br>Findings include:<br><br>R20's current physician's order dated 8/28/12, indicated R20 was receiving Lexapro 10 mg every day and Remeron 7.5 mg every night<br><br>The consultant pharmacist's review dated 5/22/12, noted R20 had been on Lexapro and Remeron since 9/2010, without an attempt to decrease or taper. The pharmacist's suggested course of action was for the physician to determine if these medications could be tapered down or to provide a risk/benefit statement.<br><br>The medical record indicated on 8/20/12, the physician documented on the pharmacist's review form, "Patient is on very low doses of both medications. Mood is good. Patient has more benefit by staying on these medications." However, the documentation lacked clinical rationale as to why an attempt to taper these medications was contraindicated. A review of the medical progress note for a routine nursing home visit dated 9/2/12, identified R20 as a very pleasant elderly female, sitting in her bed with no acute distress. | 21530 | | |

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| 21530 | Continued From page 12<br><br>On 10/18/12, at 10:10 a.m. the director of nursing (DON) stated the physician did not want any changes in the medication. The DON stated R20 had been on the same dose since 9/2010, and there had never been an attempt at tapering the medications. The DON stated this had been addressed with the physician, but the physician chose not to make any changes.<br><br>The facility policy of Monthly Medication Regime Review with a review date of 7/23/2007, noted the consulting pharmacist reviews the medication regime monthly and identifies irregularities. The recommendations are reported to the director of nursing and the prescriber. The physician accepts and acts upon suggestions or rejects and provides an explanation for disagreeing.<br><br>Suggested Method of Correction: The director of nursing could review the policies and procedures for monthly pharmacy reviews. She could work with the physicians to establish a system to ensure the reviews are acted upon in a timely manner.<br><br>Time Period for Correction: Twenty-one (21) days. | 21530 | | |
| 21535 | MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General<br><br>Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: | 21535 | | |

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| 21535 | Continued From page 13<br>A. in excessive dose, including duplicate drug therapy;<br>B. for excessive duration;<br>C. without adequate indications for its use; or<br>D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued.<br>In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, 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 system and the State Law Library. It is not subject to frequent change.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to attempt to taper an antidepressant medication and the record lacked documentation of clinical rationale as to why this would be contraindicated for 1 of 5 residents (R20) reviewed that received an antidepressant.<br><br>Findings include:<br><br>R20 had received the same dosage of Lexapro and Remeron (antidepressant medications) since 9/19/10, without the facility attempting a tapering to determine if the resident's symptoms could be controlled on a lower dosage or eliminated altogether. | 21535 | | |

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| 21535 | Continued From page 14<br><br>R20 had diagnoses including cerebral vascular accident, seizures, and depression. The annual Minimum Data Set (MDS) dated 8/30/12, indicated R20 had mild cognitive impairment, complained of feeling tired or having no energy nearly every day, and had one symptom of feeling depressed within the last 14 days.<br><br>The current physician's order dated 8/28/12, indicated R20 was receiving Lexapro 10 mg every day and Remeron 7.5 mg every night.<br><br>The consultant pharmacist's review dated 5/22/12, noted R20 had been on Lexapro and Remeron since 9/2010, without an attempt to decrease or taper. The pharmacist's suggested course of action was for the physician to determine if these medications could be tapered down or to provide a risk/benefit statement.<br><br>The medical record indicated on 8/20/12, the physician documented on the pharmacist's review form, "Patient is on very low doses of both medications. Mood is good. Patient has more benefit by staying on these medications." However, the documentation lacked clinical rationale as to why an attempt to taper these medications was contraindicated. A review of the medical progress note for a routine nursing home visit dated 9/2/12, identified R20 as very pleasant elderly female, sitting in her bed with no acute distress.<br><br>On 10/18/12, at 10:10 a.m. the director of nursing (DON) stated the physician did not want any changes in the medication. The DON stated R20 had been on the same dose since 9/2010 and there had never been an attempt at tapering to determine if tapering would be effective. The | 21535 | | |

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| 21535 | Continued From page 15<br><br>DON stated this had been addressed with the physician, but the physician chose not to make any changes.<br><br>The Medication Management policy with a review date of 7/23/2007, noted after the facility had initiated a psychopharmacological medication (other than an antipsychotic or a sedative/hypnotic), the facility attempts a gradual dose reduction during at least two separate quarters unless clinically contrainindicated. After the first year, a tapering should be attempted annually unless clinically contrainindicated. The continued use in accordance with relevant current standard of practice and the physician documents the clinical rationale for why and additional attempted dose reductions would likely impair the resident's function, increase distressed behavior or cause psychiatric instability.<br><br>Suggested Method of Correction: The director of nursing could review and revise the policy and procedures regarding unnecessary drugs. The DON could notify the physicians in writing regarding the guidelines for the use of unnecessary medications. The quality assessment and assurance committee could randomly audit records of residents identified as receiving psychotropic medications.<br><br>Time Period for Correction: Twenty-one (21) days. | 21535 | | |