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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UUL7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00353

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245238**

2.STATE VENDOR OR MEDICAID NO.
(L2) **739745302**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAHNOMEN HEALTH CENTER**
(L4) **414 WEST JEFFERSON AVENUE, PO BOX 396**
(L5) **MAHNOMEN, MN** (L6) **56557**

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 **04/26/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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):

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFE NE II 05/09/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/09/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/04/1981
(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245238
May 9, 2018

Mr. Dale Kruger, Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, MN 56557

Dear Mr. Kruger:

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 April 30, 2018 the above facility is certified 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 9, 2018

Mr. Dale Kruger, Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, MN 56557

RE: Project Number S5238028

Dear Mr. Kruger:

On March 15, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 1, 2018. 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 April 26, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 3, 2018 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 March 1, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 30, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 1, 2018, effective April 30, 2018 and therefore remedies outlined in our letter to you dated March 15, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us
cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UUL7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00353

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245238**

2.STATE VENDOR OR MEDICAID NO.
(L2) **739745302**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAHNOMEN HEALTH CENTER**
(L4) **414 WEST JEFFERSON AVENUE, PO BOX 396**
(L5) **MAHNOMEN, MN** (L6) **56557**

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 **03/01/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	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):

17. SURVEYOR SIGNATURE — Date :
Debra Vincent, HFE NE II — 03/28/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Amy Johnson, Enforcement Specialist — 04/16/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/04/1981
(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 15, 2018

Mr. Dale Kruger, Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, MN 56557

RE: Project Number S5238028

Dear Mr. Kruger:

On March 1, 2018, 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 electronically delivered CMS-2567 whereby corrections are required.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
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 April 10, 2018, 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 April 10, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 1, 2018 (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 September 1, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

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
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on February 26, 27, 28, and March 1, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On March 26th through March 1, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's 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. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and	F 584		3/26/18

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

Electronically Signed | 03/22/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 584	Continued From page 1 homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the sound levels of the dining room were conducive to a pleasant dining experience. This practice had the potential to affect all 27 residents residing in the home and who ate meals in the dining room.	F 584	03-12-2018: The maintenance department built a Sound Barrier for the ice machine in the dining room to provide noise control. 03-20-2018: Care conference sheets were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 584	Continued From page 2 Findings include: On 2/27/18, at 2:00 p.m. the resident council meeting was held in the facility dining room. R1, R18, R21 and R7 were in attendance. - At 2:09 p.m. the ice machine located in the corner of the dining room started to make a very loud noise. R7 stated "oh that machine is so loud." R21 stated the ice machine was so loud she was not able to have a conversation during meals because she was unable to hear her tablemates when they spoke. R18 stated the machine was just normally loud and she knew not to talk to others when it was running. R1 stated she did not pay any attention to the machine. When asked if the members of the resident council had expressed any concerns related to the ice machine to the facilty staff, they indicated they did not report the concern, as all of the staff knew that it was loud. The ice machine stopped running approximately four minutes after it had started. Once the machine had stopped, the council meeting resumed. - At 2:25 p.m. the ice machine began to run again. The noise from the machine was louder than the level of conversation therefore the meeting was stopped while the machine ran. - At 5:37 p.m. the evening meal was observed in the dining room. The residents in the dining room were observed conversing with others, however, when the ice machine started, the conversations between the residents stopped. R19 who was seated at a table next to the machine, stated she felt the machine was "white noise" and added she and her tablemates knew they would not be able	F 584	edited to include a section regarding resident's environment in order to address resident (or family) concerns regarding environment/noise control. 03-22-2018: Sound barrier was installed in the dining room and the tables were moved to accommodate placement of the sound barrier. 03-26-2018: Residents interviewed during activity held in the dining room. Residents noted significant improvement to the noise levels since the barrier was installed on 03/22/2018. The continued effectiveness of the sound barrier will be monitored and measured through resident council meetings and QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 584	Continued From page 3 to talk while the machine was running. On 2/28/18, at 3:50 p.m. the activity director stated she was aware the ice machine was very loud and distracting for the residents in the dinning room and had reported the concern to the maintenance director. On 3/1/18, at 9:12 a.m. the facilities director (FD) confirmed the ice machine in the dining room was noisy and indicated he had noted this himself. The FD stated they had looked at it and knew it was bad but was unaware the residents had difficulty conversing due to the noise of the machine. A policy related to the ice machine/sound levels of the facility was requested and none was provided.	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a significant change in	F 637	03/06/2018: The Director of Nursing added a 'Significant Change' segment to	4/6/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 637	Continued From page 4 status assessment (SCSA) when two or more areas of change in resident status were noted on the Minimum Data Set (MDS) for 1 of 1 resident (R26) reviewed for activities of daily living (ADL). Findings include: R26's quarterly MDS dated 10/26/17, indicated severe cognitive impairment and diagnoses which included dementia, depression and heart failure. The MDS also indicated R26 was continent of bowel and bladder, required limited assistance of one staff for dressing, and was independent with all other ADLs. R26's quarterly MDS dated 1/26/18, indicated R26 required extensive assistance of one staff for bed mobility, transfer, walk in room, walk in corridor, dressing, toilet use, and personal hygiene, required limited assistance of one staff for locomotion on and off the unit, and required supervision for eating. The MDS also indicated R26 had occasional urinary incontinence and frequent bowel incontinence. Review of the above assessments revealed a decline in the functional status of all activities of daily living and urinary and bowel continence. R26's Status Change Notification dated 2/15/18, indicated R26 had shown a "pretty severe decline" with her cognition and ADLs over the past month. She had a fall in January and hit her head hard. Her cognition had not improved and now she was not eating well and losing weight. R26's Quarterly Care Conference note dated 2/16/18, indicated nursing staff and daughter all agreed R26 had severely declined over the last	F 637	the Interdisciplinary Team meeting agenda to discuss changes in resident conditions for all residents. Meetings are held twice weekly to ensure all significant changes are discussed and documented appropriately. 03/08/2018: The significant change for R26 was completed by the MDS coordinator. 03/20/2018: MHC decided to send MDS coordinator for additional MDS education. 03/20/2018: MDS coordinator reviewed all Current MDS□s to ensure it reflects all resident□s current status. 04/06/2018: By this date, the MDS coordinator will participate in two webinars provided on MDS essentials through AANAC Training. 04/24/2018: The MDS coordinator will be attending education on the overview of MDS Sections C, D, E and Q, put on by MDH and a presentation following put on by Pathways Health in regards to state regulations. The Director of Nursing will review weekly and submit through QAPI to monitor continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 637	Continued From page 5	F 637		

month. R26 had a fall in January and daughter also stated she had seen a decline even earlier than the fall. R26 had went from limited assist to extensive to total assist with her cares and had a very difficult time turning and was not walking at all.

On 3/1/18, at 9:36 a.m. registered nurse (RN)-A confirmed R26 was independent with ADLs at the time of her assessment on 10/26/17. RN-A stated R26 experienced a fall on 1/21/18, and had waited to conduct a SCSA in order to monitor to determine if R26's abilities would return to baseline. RN-A confirmed R26 continued to require extensive assist with ADLs, and had also experienced weight loss. RN-A confirmed she should have completed a SCSA change as required.

On 3/1/18, at 1:30 p.m. the director of nursing confirmed a SCSA should have been completed for R26.

The CMS's (Centers for Medicaid and Medicare Services) RAI (Resident Assessment Instrument) Version 3.0 Manual pages 2-21 through 2-28 indicated 03. Significant Change in Status Assessment (SCSA). Assessment Management Requirements and Tips for Significant Change in Status Assessments: A SCSA is appropriate when: There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident current status to the most recent comprehensive assessment and any subsequent quarterly assessments; and The resident's condition is not expected to return to baseline within two weeks. Guidelines for Determining a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 637	Continued From page 6 Significant Change in Resident Status: The final decision what constitutes a significant change in status must be based upon the judgment of the IDT (interdisciplinary team). MDS assessments are not required for minor or temporary variations in resident status - in these cases, the resident's condition is expected to return to baseline within two weeks. However, staff must note these transient changes in the resident status in the resident's record and implement necessary assessment, care planning, and clinical interventions, even though an MDS assessment is not required. Some Guidelines to Assist in Deciding If a Change is Significant or Not: Decline in two or more of the following: Any decline in an ADL physical functioning area where a resident is newly coded as extensive assistance, total dependence, or activity did not occur; Resident incontinence pattern changes or there was placement of an indwelling catheter.	F 637		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders.	F 655		3/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 655	Continued From page 7 (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a baseline care plan was developed, implemented and a copy was given to the resident and/or representative within 48 hours of admission which addressed the individualized needs for 1 of 1 resident (R78) recently admitted to the facility. Findings include:	F 655	03/05/2018: MDS coordinator revised the Admission Assessment to include all components required by 483.21 for a Baseline Care Plan to be completed upon admission and placed in the chart within 48 hours of admission. A checklist was added to the Baseline Care Plan to include instructions to review with resident/guardian the components of the Baseline Care Plan to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 655	Continued From page 8 R78's Resident Face Sheet indicated R78 was admitted to the facility on 2/23/18, with diagnoses including chronic pain syndrome, rheumatic mitral insufficiency, a cardiac defibrillator and diabetes mellitus. The Assessment on Admission dated 2/23/18, indicated R78 did not have trouble with communication, he was continent of bowel and bladder, transferred with assist of two staff or a standing lift, displayed poor balance, no skin concerns and required blood sugar monitoring. The admission orders dated 2/23/18, indicated R78 required multiple medications including but not limited to: Coumadin (a blood thinner) 5 milligrams (mg) daily, Vitamin K 100 micrograms (vitamin used to thicken blood) daily, Novolog insulin 30 units daily, lasix (diuretic medication) 80 mg three times a day, zoloft (antidepressant medication) 50 mg daily, Nitrostat 0.4 mg (medication for chest pain) as needed, along with inhalers, oxygen, blood pressure medications, vitamins and pain medications. The admission assessment did not address the aforementioned medications. Review or R78's Progress Notes identified the following: - 2/23/18, R78 was admitted to the facility from home as he could not longer walk or get up by himself. - 2/24/18, R78 complained of pain in his legs and was given Tylenol. - 2/24/18 at 12:00 a.m. R78 was incontinent of bowel and bladder. R78 required assist of two staff and a standing lift to transfer. - 2/26/18, at 6:06 a.m. R78 requested a nebulizer	F 655	person-centered care and to ensure staff provide resident and family/guardian with a copy of the baseline care plan and medication summary. All Admissions are discussed at IDT twice weekly. 03/20/2018: The Baseline Care Plan was added to the Admission Checklist for staff to complete within 48 hours as well as to the IDT agenda to be reviewed twice weekly. This will be monitored by the Director of Nursing at every admission and submitted through QAPI to monitor continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 655	Continued From page 9	F 655		

for shortness of breath.
- 2/26/18, at 10:50 a.m. R78 requested stronger pain medications.
- 2/26/18, at 3:50 p.m. R78 requested to have his inhaler at bedside.

On 2/27/18, at 6:34 p.m. R78 was observed to receive assistance from nursing assistants (NA)-E and NA-F to transfer from the commode to bed. R78 was able to stand while in the standing lift. R78 was not observed to attempt to complete perineal cares. Once in bed, R78 was noted to have a quarter sized (approximately) scabbed area on his left shin. An albuterol inhaler was noted at R78's bedside.

R78's medical record lacked evidence of an initial care plan to direct the staff how to care for diabetes, pain, bleeding tendencies, skin concerns, breathing concerns, muscle weakness or cardiac defibrillator. R78's record also lacked evidence of how he or his representative had been given information about his care in writing within the first 48 hours after admission.

On 2/28/18, at 9:35 a.m. the director of nurses stated registered nurse (RN)-A reviewed all of the initial care plans with the resident and families and was not sure when the initial care plan had been given to R78 or his family.

On 2/28/18, at 3:45 p.m. RN-A stated R78 was admitted to the facility on 2/23/18 and she had not had a chance to complete a 48 hour care plan. RN-A stated it was not part of her admission routine to give the resident and/or representative a copy of the care plan within 48 hours. RN-A stated the first care conference would be held after the completion of the Minnimum Data Set

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 655	Continued From page 10 (MDS) however, an MDS had not yet been completed for R78. RN-A stated she was aware of the regulation related to providing the resident and/or representative with a baseline care plan within 48 hours of admission but had not developed a plan to ensure they were shared with the residents or families. A policy related to baseline care plans was requested and none was provided.	F 655		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure elevated blood sugar readings were acted upon for 1 of 2 diabetic residents (R8) reviewed, and failed to monitor and/or inform the physician of elevated blood pressure readings for 2 of 2 residents (R8 and R24) reviewed who had elevated blood pressure readings without follow up. Findings include: R8's quarterly Minimum Data Set (MDS) dated 11/2/17, indicated R8 had diagnoses including hypertension and diabetes mellitus. The MDS	F 684	03/02/2018 The Routine Vitals policy was developed for nursing staff by the Director of Nursing with advisement from the Nursing Home Medical Director. It includes procedures regarding when blood pressure readings need to be reported to a medical provider. 03/02/2018 The Director of Nursing and MDS Coordinator reviewed all resident blood pressures and blood sugars for the last 4 months. 03/02/218: The Director of Nursing edited	3/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 684	Continued From page 11 indicated R8 was independent with her activities of daily living and utilized insulin daily. R8's admission MDS dated 8/2/17, identified diagnoses of hypertension and diabetes along with daily insulin use. R8's care plan dated 2/8/18, directed the staff to provide a diabetic diet, monitor blood sugars and signs and symptoms of hyper/hypo glycemia (hi/low blood sugars). The care plan did not direct the staff how to care for R8 if the blood sugars were critically high or low. R8's Physican Order report dated 1/28/18 - 2/28/18, included an order dated 11/1/17, which directed staff to monitor R8's blood glucose levels once a day at various times. Review of R8's blood sugar levels from 12/1/17 - 2/28/18, revealed R8's blood sugars ranged from the normal range of 80-120 to critically high levels greater than 400. R8's medical record did not indicate she suffered from low blood sugars but did indicate she had three incidents of high blood sugars. - On 1/23/18, R8's glucose level was 427. - On 2/8/18, R8's glucose level was 407. - On 2/13/18, R8's glucose level was 406. R8's medical record lacked documentation related to the high glucose levels, notification of the physican or additional monitoring of R8's condition at the time of the high glucose levels. On 2/28/18, at 1:10 p.m. licensed practical nurse (LPN)-A stated if R8 were to have a blood sugar greater than 400, the physican was to be notified and would most likely order additional insulin for	F 684	the Bath Sheets to include revised instructions established in the Routine Vitals policy. Per policy, all vitals will be entered by the charge nurse and re-checks will be performed by the nurse when blood pressures are outside of established parameters. 03/06/2018: Director of Nursing and MDS coordinator started reviewing current blood pressures and blood sugars. Results were reviewed at weekly IDT meeting. Blood pressure and blood sugar readings will be reviewed weekly for 4 weeks and then monthly thereafter by the Director of Nursing and MDS coordinator. 03/13/2018: Any readings outside of parameters defined in the Routine Vitals policy were given to the medical director and were reviewed at resident rounds. 03/21/2018: The MDS coordinator reviewed and updated all Care Plans for residents with diabetes and hypertension providing direction for staff regarding residents with these conditions. 03/21/2018 The MDS coordinator updated all EMAR Blood Sugar/Accu-Check orders to include parameters of when to notify a medical provider. 03/30/2018: The Director of Nursing or designee will have educated all nursing staff/TMAs on the Routine Vitals policy and updated eMAR Standing Orders to ensure that blood pressures and blood sugars are being addressed accordingly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 684	Continued From page 12 R8. LPN-A could not recall needing to call the physican regarding R8's blood sugars. -At 1:30 p.m. registered nurse (RN)-A confirmed R8's care plan did not direct the staff how to care for R8 when her blood sugars were elevated. RN-A stated the facility standing orders directed the staff to notify the primary physican or an on call physican for blood sugars greater than 400. Upon review of R8's medical record, RN-A confirmed R8 had blood sugars greater than 400 and the record lacked evidence the physican had been notified, a progress note had been completed or the blood sugar had been rechecked for accuracy. RN-A stated R8 had not received appropriate care for a diabetic resident. R8's care plan did not address hypertension. R8's Physican Order Report dated 1/28/18-2/28/18, included orders for amlodipine (blood pressure medication) 10 milligrams (mg) daily. Review of R8's weekly vitals from 11/1/17 - 2/28/18, indicated R8 had been identified with increased blood pressure, however, additional monitoring had not been completed. Acceptable range of blood pressure according to the facility computerized medical record system was 85-160 for the systolic (top number) and 45-90 for the diastolic (bottom number). Review of R8's blood pressure report from 11/1/17 - 2/28/18, identified the following abnormal pressure readings: - 11/8/17, R8's blood pressure was 185/93. - 11/15/17 , R8's blood pressure was 164/85. - 1/23/18, R8's blood pressure was 169/89.	F 684	PRN and part-time staff will be educated on their next shift worked. 3/26/2018: nursing staff will monitor the blood sugars daily, the Director of Nursing or the MDS Coordinator will monitor blood sugars every weekday for residents that require blood sugar monitoring per provider order. Irregularities in blood sugars over 400 or residents who present with symptoms, the provider will be notified immediately. The Director of Nursing or MDS Coordinator will follow up on provider orders for treatment. The notification will be documented in the residents medical record. Residents with blood sugar monitoring will be reviewed at the weekly IDT meeting. 3/26/2018: the Director of Nursing or the MDS Coordinator will monitor the blood pressure readings for all residents every weekday. The residents provider will be notified the blood pressure reading that is not within the specified parameters for the resident. The Director of Nursing or MDS Coordinator will follow up on provider orders for treatment. The notification will be documented in the residents medical record. Residents with hypertension monitoring will be reviewed at the weekly IDT meeting. The monitoring, documentation of provider notification and follow through with provider orders will be brought through the QAPI process to monitor continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 684	Continued From page 13	F 684		

R8's medical record lacked documentation related to the high blood pressure readings, what R8 was doing when the blood pressure was monitored or if the pressure was rechecked for accuracy.

On 2/28/18, at 1:10 p.m. LPN-A stated if a blood pressure was noted to be high, the resident was to be allowed to relax and staff should recheck the pressure. If it was determined that the pressure continued to be high, the physican was to be notified or the resident may need to be sent to the emergency room for further evaluation.

-At 1:40 p.m. RN-A confirmed R8's care plan did not address hypertension and stated she was not aware R8 had been experiencing high blood pressure and the physican had not been notified. RN-A stated if a high blood pressure was identified, the staff were to document what R8 was doing, if she was anxious at the time and if alternative interventions such as having R8 relax and also results of the blood pressure when rechecked. RN-A reviewed R8's medical record and confirmed the record lacked documentation related to R8's elevated blood pressure and/or notification of the physican. RN-A stated on 2/27/18, she had printed off R8's blood pressure report for R8's physican to review.

R24 had elevated blood pressure readings and the staff failed to monitor the elevated readings and/or notify the physician.

R24's annual MDS dated 2/1/18, indicated diagnosis of hypertension and depression. The MDS indicated R24 had moderate cognitive impairments and required extensive assistance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 684	Continued From page 14	F 684		

with all activities of daily living.

R24's Physican Order Report dated 1/28/18 - 2/28/18, included an order for Lisinopril (blood pressure medication) 40 mg daily and metoprolol succinate (blood pressure medication) extended release 100 mg daily.

R24's Care Plan dated 2/7/18, did not address hypertension.

Review of R24's blood pressure report dated 12/1/17 - 2/28/18, indicated the following high blood pressures:

- On 1/3/18, R24's blood pressure was 192/122.
- On 1/9/18, R24's blood pressure was 144/82.
- On 1/16/18, R24's blood pressure was 143/102.
- On 1/17/18, R24's blood pressure was 160/94.
- On 1/24/18, R24's blood pressure was 164/76
- On 2/6/18, R24's blood pressure was 176/86.
- On 2/20/18, R24's blood pressure was 149/99.

R24's medical record lacked documentation related to elevated blood pressures. R24's condition at the time of the elevated pressures was not identified and follow up actions were not documented.

On 2/28/18, at 9:45 a.m. the director of nurses (DON) reviewed R24's blood pressure. The DON confirmed R24 was having sporadic elevated blood pressures and stated when an elevated pressure was identified, the nurse should have evaluated the resident and rechecked the blood pressure. The DON stated she would expect RN-A to report concerns to the physicians.

-At 1:50 p.m. RN-A stated she would expect the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 684	Continued From page 15 elevated blood pressures to be rechecked by the wing nurse and a progress note to be completed. RN-A verified R24's care plan did not address hypertension. RN-A also reviewed the medical record and confirmed the record lacked documentation of what R24 was doing at the time of the identified increased pressure, interventions attempted to reduce the pressure and the elevated pressures had not been reported to R24's physican. . A policy related to the care for diabetic residents and hypertensive residents was requested and none was provided.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 688	03/07/2018: The Director of Nursing	3/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 688	Continued From page 16 review, the facility failed to provide range of motion services to 2 of 2 residents (R24 and R25) as directed. Findings include: R24's annual Minnimum Data Set (MDS) dated 2/1/18, indicated R24 had diagnoses of dementia, diabetes mellitus and hypertension. The MDS indicated R24 displayed moderate cognitive impairment, required extensive assistantce of one for all activities of daily living and required extensive assist of one staff for ambulation. The Activities of Daily Living Care Area Assessment (CAA) dated 2/1/18, indicated R24 required assistance with ambulation however, she utilized a wheelchair on and off of the nursing unit for mobility. R24's Care Plan dated 2/20/18, indicated R24 was to participate with restorative nursing three times a week. R24's Therapy Assessment completed by the occupational therapist dated 1/2/18, indicated R24 had limited range of motion in her left arm and displayed difficulty walking. The therapist developed a functional maintence program (FMP) to be completed three times a week. R24's progress note dated 1/18/18, completed by the physical therapist indicated R24 had a functional maintenance program developed for lower leg exercises and ambulation with a front wheeled walker. On 2/28/18, at 7:30 a.m. R24 was observed to participate in morning cares with assistance of nursing assistant (NA)-A. R24 was observed to	F 688	removed the current Rehab Aide from the therapy position. 03/09/2018: MHC offered the therapy position to a COTA, who accepted the position part-time until May and will be full-time thereafter. 03/16/2018: MHC contracted with Health Dimensions Rehab (HDR) to have one of their employees (a Rehab Aide) administer the rehab program on a temporary basis until May. The COTA in collaboration with the temporary Rehab Aide will monitor and coordinate the program until the COTA can take over the position on a full-time basis. Attendance by the rehab aide/COTA at IDT meetings will be continued. 03/20/2018: R24 and R25 was evaluated by therapy and their programs were implemented immediately by the temporary Rehab Aide. 03/20/2018: The MDS coordinator began monitoring the rehab program to ensure it is being performed and documented correctly twice monthly and monthly thereafter to monitor continued compliance. This information will also be submitted through our QAPI program. 03/30/2018: A walking program will have been implemented by the therapy department. 04/30/2018: The therapy department will have completed education on the newly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 688	Continued From page 17 have limited range of motion in her left shoulder. R24 did not complain of pain as she assisted with washing her face, hands and upper body. R24 was able to dress with the assistance of NA-A. At 7:38 a.m. NA-A placed a walker in front of R24. R24 was able to hold the walker with both hands and stood up with the assistance of NA-A. At 7:40 a.m. a NA-F entered the room and assisted to transfer R24 from the bed to the wheelchair. R24 took very small steps and was unsteady during the transfer. Review of R24's January 2018, Restorative Nursing Plan indicated R24 was to utilize a NuStep machine for 10 minutes and complete hand exercises x 20 repetitions three times a week. The program was established on 1/11/18. Review of the documentation indicated R24 participated in the restorative program seven times in 20 days. The restorative program did not include an ambulation program. The February 2018, Restorative Nursing Plan directed the staff to ensure R24 utilized the NuStep machine for 10 minutes and the hand exercises for 20 repetitions three times a week. The documentation indicated R24 had participated in the restorative program on four occasions. The program did not include an ambulation program. On 2/28/18, at 9:30 a.m. NA-D stated she was the restorative aide. She stated R24 would occasionally allow the staff to assist with the exercise program however, there were days she refused to participate. NA-D stated R24 was to utilize the NuStep machine instead of ambulating with the walker. NA-D also stated she was frequently reassigned to do personal cares	F 688	implemented walking and rehab program will be provided by the therapy department. PRN and part-time staff will be educated on their next shift worked. 04/30/2018: All other residents will have been evaluated by the therapy department to determine if a resident has a need for a restorative or a functional maintenance program to be developed or if they will continue their current program as is.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 688	Continued From page 18	F 688		

instead of restorative nursing. She stated when she was reassigned to perform personal cares, the restorative nursing services was not completed.

During interview on 2/28/18, at 9:40 a.m. the director of nurses (DON) stated she did not review the restorative nursing program rather RN-A was in charge of monitoring the restorative nursing program.

- At 1:30 p.m. R24 was observed to stand with the assistance of NA-D and NA-A. R24 used a front wheeled walker and ambulated 200 feet without difficulty.

- At 1:40 p.m. RN-A stated R24 was to receive assistance to ambulate and exercise three times a week. RN-A reviewed R24's restorative nursing documentation and confirmed R24 had not received assistance with the restorative program as directed but had not sustained a decline in her physical mobility.

R25's quarterly MDS dated 12/22/17, indicated R25 had dementia, osteoarthritis, displayed severe cognitive impairment, required extensive assist with all activities of daily living, and displayed bilateral limited range of motion.

R25's Activities of Daily Living CAA dated 3/21/17, indicated R25 utilized a walker and assist of one staff, however she utilized a wheelchair on and off of the nursing unit for mobility when her knees were bothersome.

R25's care plan dated 1/16/18, indicated R25 was placed on a functional maintenance program (FMP) three times a week.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 688	Continued From page 19 On 2/28/18, at 8:30 a.m. NA-C and NA-B were observed to assist R25 with morning cares and to transfer a mechanical stand device. NA-B spoke with R25 who verbalized understanding and participated with the transfer to the toilet and then to her wheelchair without any observed issues. NA-C stated she had not observed any changes in R25's ability to transfer in the past couple of months. Review of R25's January 2018, Restorative Nursing Plan indicated R25 worked with physical therapy three times weekly and a new FMP was implemented 2/1/18, to maintain ability to transfer from bed to wheelchair utilizing a mechanical stand. The new restorative plan included supine exercises, ankle pumps, straight leg raises, bed slide, and hip abduction for 15 repetitions, sitting exercises included knee curls for 15 repetitions. Additionally, the program indicated to utilize the NuStep machine for five minutes or as tolerated. Review of the documentation indicated R25 participated in the restorative program zero times in 28 days. The record lacked indication why services were not provided and did not indicate refusals. 2/28/18, at 12:03 p.m. NA-D stated R25 had ROM exercises to be completed three times weekly and to utilize the NuStep machine for five minutes or as tolerated. NA-D stated R25 participated with the NuStep last week for 20 minutes. NA-D confirmed the plan lacked documentation related to R25's participation. NA-D stated she frequently got pulled to the floor and could not complete the restorative assignments.	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 688	Continued From page 20 At 12:44 p.m. RN-A stated R25 would often refuse to participate with her FMP and confirmed NA-D had been pulled from restorative services and had been frequently working on the floor. RN-A confirmed R25 lacked documentation of her FMP and stated she had observed R25 transfer and verified there had not been a decline in her ability to transfer. At 12:59 p.m. the DON confirmed in the past month, the facility had had issues with the restorative services due to staff illnesses's and stated the facility was in the process of actively hiring a certified occupational therapy assistant (COTA) to assume the restorative program. A policy related to restorative nursing was requested and none was provided.	F 688		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732		3/8/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 732	Continued From page 21 §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the required nurse staffing information was posted daily. This had the potential to affect all 28 residents residing in the facility and/or visitors who may wish to view this information. Findings include: On 2/28/18, at 8:15 a.m. the facility's posted nursing hours were observed on a wall by the front entrance. The posting indicated licensed nursing staff as 4/32, and unlicensed staff as 4/32. The posting lacked facility census information, identification of nursing disciplines, and actual hours worked. In addition, a Nursing Home Daily Staffing Plan was observed posted	F 732	02/28/2018: The Director of Nursing and staffing coordinator revised the staffing sheets to include the facility name, current date, resident census, the total number of actual hours worked by licensed and unlicensed staff. It was posted in a prominent place readily accessible to residents and visitors. 02/28/2018: Staffing coordinator was educated on the requirements needed for the daily staffing sheet and is responsible for filling the sheets out daily including weekends. 03/08/2018: The Director of Nursing posted on the communication board and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 732	Continued From page 22 on the wall behind the nursing station desk. The staffing plan lacked the identification of nursing disciplines, actual hours worked, and the facility census. On 2/28/18, at 8:25 a.m. Registered Nurse (RN)-A stated the nurse staff posting previously indicated the actual hours worked and stated the facility had staff working various hours on each shift. RN-A stated the facility staffing plan forms are completed a week in advance by the scheduler and if someone did not work their name was crossed off. At 8:30 a.m. the director of nursing (DON) confirmed the facility licensed and and unlicensed staff worked various shifts on a daily basis. The DON confirmed the nurse staff postings lacked the facility census, identification of nursing disciplines, and actual hours worked. The DON stated she was unaware the posting required the specific staffing information and verified the facility did not have a policy related to the nurse staff posting.	F 732	the nightly census binder with instructions of how to correct daily staffing sheets for call-ins/no-shows, added staff, and census information including on the weekends. The sheets will be checked Monday through Friday daily for two weeks by the Director of Nursing or designee to ensure that they are updated appropriately, weekly for two months and monthly thereafter to monitor continued compliance. This information will also be reviewed through our QAPI program.	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 880	Continued From page 23	F 880		

and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 880	Continued From page 24 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure infection control practices were maintained for 1 of 6 clients (R18) who received nail care with a community used dremel tool without cleaning in between resident use; for 2 of 2 residents (R24, R78) who were observed to receive personal cares without staff performing hand hygiene, and for 2 of 3 residents (R10, R2) observed in droplet isolation. In addition, the facility failed to maintain safe linen practices related to the storage of soiled laundry and mop heads. This practice had the potential to affect all 24 residents residing in the facility. Findings include: Nail care On 2/26/18, at 11:31 a.m. R18 was observed seated in a beauty shop chair with her shoes off. The activity director/licensed practical nurse (LPN) was seated on the floor trimming R18's	F 880	Nail Care 03/01/2018: All dremels used for nail care were discontinued. The Director of Nursing removed the dremels from the activities room and the med cart. Each resident has their own files and clippers. Hand Hygiene and Droplet Isolation 03/01/2018: NA-A was educated on performing combined personal cares, peri-cares, hand washing and infection control techniques including proper use of PPE to include what PPE to use, how to put on and how to take off PPE, how to dispose of PPE and when to change PPE while doing cares, review of the standard precaution signage, review of proper cleaning of equipment after use, and those used for resident in isolation. 03/03/2018: NA-E was educated on performing combined personal cares, peri-cares, hand washing and infection	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 880	Continued From page 25 toenails with a dremel (a tool used for sanding small pieces of wood.) R18's toenails were thick and were not able to be cut with a toenail clipper. On 2/27/19, at 12:30 p.m. the north medication cart was observed with LPN-A. A dremel tool was observed in the top drawer of the cart with a white residue noted on the dremel sanding bit and in the drawer section which held the dremel. LPN-A confirmed the white residue was from the dremel and would contain remnants of toenail material from the residents. When asked how the tool was cleaned, LPN-A stated she did not use the tool and did not know how the dremel was cleaned. - At 12:53 p.m. registered nurse (RN)- A stated that she had utilized the dremel tool to trim resident's toenails, however she did not clean the tool. RN-A stated she was aware the dremel had additional bits but was unaware when or if the bits were cleaned. RN-A stated after she had used the dremel, she simply placed it back in the medication cart. - 2:30 p.m. the activity director/LPN stated the facility currently had 6 or 7 resident who required nail care with a dremel. The facility had two dremel tools, one in the activity department and one in the north medication cart. The activity director stated she cleaned the tool and the bit with alcohol between residents. The activity director confirmed the dremel bit was a small (1/4 inch diameter) bit which was covered with sand paper and alcohol did not have the ability to clean sandpaper. The activity director stated the staff had the ability to change the dremel bits between residents however, the staff did not change them between resident use.	F 880	control techniques including proper use of PPE to include what PPE to use, how to put on and how to take off PPE, how to dispose of PPE and when to change PPE while doing cares, review of the standard precaution signage, review of proper cleaning of equipment after use, and those used for resident in isolation. 04/30/2018: All staff providing direct cares will be trained and educated on performing combined personal cares, peri-cares, handwashing and infection control techniques including proper use of PPE to include what PPE to use, how to put on and how to take off PPE, how to dispose of PPE and when to change PPE while doing cares, a review of the standard precaution signage, a review of proper cleaning of equipment after use, and those used for resident in isolation. Director of Nursing, Designee and Infection Preventionist will continue to work together as a team to educate and train staff in proper Hand Hygiene and Droplet Isolation precautions. Hand Hygiene will be monitored once daily by nursing staff and droplet precautions once daily if implemented for a resident for two weeks, weekly for 2 months and monthly thereafter to monitor continued compliance. Information will also be reviewed at our QAPI meetings. Part time and PRN staff will be educated on their next worked shift. 04/30/2018: All dietary, maintenance and housekeeping staff will be educated on hand washing and infection control	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 880	Continued From page 26 Review of the manufactures instructions for the dremel 7300 model from (www.dremel.com) did not include cleaning instructions. The instruction indicated the tool was intended to function as a grinder, sander, wire brush, polisher, carving or cut off tool. The instructions did not direct the user how to use it as a nail clipper. - At 3:44 p.m. the activity director stated the facility did not have a policy related to the use and cleaning of the dremel for nail care. On 2/28/18, at 12:30 p.m. the director of nursing (DON) confirmed the facility routinely trimmed resident toenails with the use of a dremel however, procedures related to cleaning the dremel had not been developed and the facility did not have a policy related to dremel use. Hand Hygiene The staff failed to perform hand hygiene during cares for R78. On 2/27/18, at 6:34 p.m. R78 was observed seated on a commode in his room connected to a standing mechanical lift. Nursing assistant (NA)-E applied gloves as NA-F used the lift to stand R78 from the commode. NA- E provided perineal cares as R78 had a bowel movement while on the commode. With the same gloved hands, NA-E pulled up R78's pants, removed the commode, arranged R78's wheelchair by unlocking the breaks, touching the wheelchair handles and positioned the chair under R78. R78 was then lowered into the chair by NA-F. Once in the chair, R78 stated he wanted to go to bed. NA-F lifted R78 out the chair and turned him	F 880	techniques including proper use of PPE to include what PPE to use, how to put on and how to take off PPE, how to dispose of PPE and when to change PPE, review of the standard precaution signage, review of proper cleaning of equipment after use and those used for resident in isolation. Part time and PRN staff will be educated on their next worked shift. Soiled Laundry 03/07/2018: High capacity linen trucks were ordered for bagged laundry collection in the laundry room while waiting to be laundered. Once linen trucks arrive, the facility manager will start educating staff on proper handling of laundry in the laundry area 04/30/2018: Staff will have been educated by the facility manager on proper handling of laundry in the laundry area. Part time and PRN staff will be educated on their next worked shift. Laundry staff will monitor for compliance and Facility Manager will collect the data and bring through QAPI.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 880	Continued From page 27	F 880		

towards the bed. NA-E continued to wear the same gloves as she raised the bed via the electronic control, adjusted R78's pillows and blankets and assisted R78 into bed. NA-F and NA-E proceeded to scoot R78 up in the bed by holding onto his blankets. NA-E lowered the bed with the electric control, covered R78 up and picked up the commode. NA-E opened the door to the bathroom and emptied the commode. Upon exiting the bathroom, NA-E was observed to remove her gloves and wash her hands in R78's sink.

- At 6:45 p.m. NA-E confirmed she had not removed her gloves or washed her hands until she had completed all cares for R78 and should have.

The staff failed to perform hand hygiene for R24.

On 2/28/18, at 7:30 a.m. NA-A was observed to assist R24 with personal cares. NA-A assisted R24 with washing her face, hands, upper body and perineal area. R24 had been incontinent of urine. NA-A was observed to wear gloves while assisting R24 with bathing and dressing. Once R24 was dressed, NA-A transferred R24 into a wheelchair and removed her gloves. NA-A wheeled R24 to the sink and picked up R24's denture cup. The State Agency staff, stopped NA-A from directly touching the dentures. NA-A confirmed she had not washed her hands since completing perineal cares and removing her gloves. NA-A then washed her hands and proceeded to assist R24 to complete oral cares.

On 2/28/18, at 12:00 p.m. the DON and infection control preventionist confirmed the staff were to remove their gloves and perform hand hygiene

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 880	Continued From page 28	F 880		

while completing personal cares

The Standard Precautions policy dated 6/2017, directed the staff to perform hand hygiene before and after performing personal cares for a resident.

Droplet Isolation

On 2/26/18, at 10:00 a.m. upon entrance to the facility, an isolation cart was not observed by R10's room.

On 2/27/18, at 6:50 p.m. an isolation cart containing a box of masks and two boxes of gloves was observed outside of R10's room. A large garbage can (without a cover) was also observed in the hallway outside of R10's room.

- At 6:51 p.m. RN-B and NA-E were observed to apply masks and gloves and entered R10's room. Upon exiting the room, the staff removed the gloves and masks, tossed them in the garbage outside of R10's room, and performed hand hygiene with alcohol based cleanser in the hallway. RN-B stated R10 had been exposed to influenza A and was now showing signs of influenza. R10 had been tested for influenza and the results were negative however, he had been placed on droplet precautions. RN-B stated the staff were to use masks and gloves while caring for R10.

On 2/28/18, at 8:10 a.m. NA-C was observed to push the full body mechanical lift into R10's room, step back out of the room and apply gloves and a mask. NA-C reentered R10's room and shut the door. At 8:12 a.m. NA-C exited R10's room while wearing the mask (no gloves observed) and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 880	Continued From page 29	F 880		

walked to the nurses station. Once to the nurses station, NA-C removed the mask. NA-C talked to the nurse at the nurses station and returned to R10's room. NA-C was not observed to wash her hands after the removal of the mask. At 8:15 a.m. NA-C stopped at R10's room, donned gloves and a mask and entered the room.

At 8:16 a.m. NA-C exited R10's room with the mechanical lift. NA-C removed her gloves and mask and discarded them in the garbage can in the hallway. NA-C wiped the mechanical lift off with germicidal cleansing wipes. NA-C stated R10 was on droplet precautions and gloves and masks were to be used while caring for him. NA-C stated the masks could be worn in the hallway if the staff were going right back into the resident room.

The Standard Precautions policy dated 6/2017, directed the staff to care for the patient in droplet isolation to utilize personal pretective equipment. The policy directed the staff to perform hand hygiene prior to donning and after removing personal protective equipment. The policy also directed a surgical mask be worn upon entering the room and removal and disposal of the mask upon leaving the room.

On 2/28/18, at 2:00 p.m. the infection control preventionist confirmed R10 was on droplet precautions due to possible influenza exposure. The infection preventionist stated the gloves/masks were to be removed upon exiting the room and hand hygiene was to be performed.

Staff did not donne appropriate personal protective equipment (PPE) during meal tray delivery.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 880	Continued From page 30	F 880		

On 2/27/18, at 4:57 p.m. dietary aide (DA)-A was observed pushing a cart which contained four meal trays from the kitchen.

--At 5:02 p.m. DA-A wheeled the cart outside R2's room. A blue sign identifying droplet precautions was attached to R2's room door along with gloves and masks in containers on the door. DA-A entered R2's room with a meal tray without donning PPE. She placed the tray on the overbed table, moved R2's wheelchair and then moved the table over the bed. DA-A left the room, applied hand sanitizer and returned the cart to the kitchen.

--At 5:07 p.m. DA-A confirmed she had not donned PPE prior to entering R2's room and stated she did not know what droplet precautions were.

On 03/01/18, at 1:27 p.m. the DON confirmed she would expect all staff to put on the proper PPE prior to entering a room identified as requiring isolation precautions.

Soiled Laundry:

On 2/28/18, at 12:30 p.m. the laundry facility was observed with the infection control preventionist. Upon entering the soiled linen room, seven bags of dirty personal laundry (clothing) in bags were observed on the floor. In the corner of the room, a five gallon bucket was observed overflowing with soiled mop heads. The mop heads were balanced in the bucket as they touched the walls of the soiled linen room. Eight empty covered laundry barrels were also observed in the soiled linen room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 880	Continued From page 31 At 12:35 p.m. the infection control preventionist confirmed the laundry was on the floor and the mop heads were overflowing in the bucket and against the wall, yet there were multiple empty laundry bins available for use. The infection control preventionist stated there were no laundry staff at the facility at time of the tour and she did not know why the soiled laundry was not in appropriate bins. The infection control preventionist confirmed the laundry was not stored appropriately. The Soiled Laundry and Bedding policy dated 3/2017, directed the staff to ensure contaminated laundry was stored in a bag or container. The policy did not direct the staff not to store bags of laundry on the floor.	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain resident rooms and furnishings in good repair and/or a clean and sanitary condition for 4 of 4 resident rooms and 1 common use room (RM32, RM33, RM37, RM29, shower room) reviewed for maintenance concerns. Findings include: On 3/1/18, at 8:55 a.m. a board approximately 5	F 921	03/06/2018: Towel dispenser was installed in RM 32. 03/08/2018: The door knob was fixed in RM 37 and the padded board was removed from the vertical pipe behind the toilet seat. The padded board was removed from the vertical pipe behind the toilet seat in the shower room. 03/16/2018: All walls were patched and	3/19/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 921	Continued From page 32 inches (") by (x) 10" containing three pegs was observed on top of a counter height ledge at the nurses station. Each peg contained a stack of paper slips approximately 3" x 4" with a hole punched in the top of each slip. The facilities director (FD) indicated the first stack of slips were blank work orders, the second stack of slips were pending work orders and the third stack were completed work orders. FD stated staff filled out a blank two part slip when a concern was identified and placed it on the second peg. When the concern was addressed and the work order completed, maintenance staff placed the yellow copy of the two part slip on the third peg. Two pending work orders were observed; one for a wheelchair concern and one for a concern with a bed. FD indicated they typically conducted room rounds monthly looking for issues such as concerns with bed rails and would also look around the room for concerns regarding the walls/paint which were an ongoing issue. At 9:12 p.m. FD indicated he had another maintenance staff member complete the room rounding and provided a clipboard with the rounding results. The results identified the last rounds was completed 2/15/18, and identified beds and chairs were checked. No wall/paint issues were identified. A tour of the facilty was completed with FD who confirmed the following identified room maintenance concerns and verified they were in need of repair and/or cleaning: --Room (RM) 32: No paper towel dispenser was available near the sink. R19 was in the room at the time of the tour and indicated she would use paper towels if they were available to her. FD indicated he did not have an answer as to why	F 921	painted. 03/19/2018 The Medical Device Reporting Policy was updated to be called the Equipment and Building Maintenance Reporting Policy and edited to address maintenance/repair of walls or furnishings. The facility manager will coordinate continued monthly rounds to include wall and equipment inspections in all resident rooms and document findings on the Monthly Room Inspection Report. Nursing staff will continue to use the Duplicate Maintenance Form to notify maintenance of items that may be needing repair and maintenance department will continue their continuous rounding on Duplicate Maintenance Forms during normal business hours. Maintenance Staff is on call 24 hours a day 7 days a week and their contact information is readily available at the nurses' station. Facility Manager will monitor continued compliance and information will be reviewed through our QAPI program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 921	Continued From page 33	F 921		

this room had not had a dispenser.

--RM33: The lower wall behind the bed contained multiple deep gouges into the sheetrock covering and area approximately 12" x 8". The exposed sheetrock was uncleanable.

--RM37: The door knob was loose on bathroom door and the wall by the head of the bed contained a deep gouge approximately 4" x 1 1/2". The vertical pipe behind the seat of the toilet was covered by a padded board approximately 12" x 15". The board was covered in a black vinyl material and affixed to the toilet bar with four elastic straps. FD confirmed the straps were stiff with a white dried substance. FD indicated the vinyl covered padded board was wiped down for cleaning but confirmed the straps needed cleaning. FD also confirmed a 4" x 4" tile was missing from the wall behind the toilet.

--RM 29: The wall behind the recliner contained a 2" wide gouge into the sheet rock and multiple gouges covering an area approximately 12" x 5" were observed behind the bed. The exposed sheetrock was uncleanable. A gap of approximately 1/4" to 1/2" was observed on the top and right side of the electrical outlet behind the bed.

--Shower room: The vertical pipe behind toilet seat was covered by a padded board approximately 12" x 24". The vinyl covering in the upper right corner of the padded board was cracked and worn.

The Medical Device Reporting policy dated 5/2015, indicated maintenance staff would perform monthly room checks on resident and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 921	Continued From page 34 patient rooms, checking mattresses, grab bars, call lights, wheelchairs, mechanics and slings of lifts, bathrooms and sinks, brakes, etc. The policy did not address maintenance/repair of walls or furnishings.	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING **01 - 1969 BUILDING WITH 1975 ADDITION** B. WING _____	**03/01/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	**414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Mahnomen Health Center (Nursing Home) 01 Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code (NFPA 99). PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/22/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING **01 - 1969 BUILDING WITH 1975 ADDITION** B. WING _____	**03/01/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	**414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Mahnomen Health Center (Nursing Home) was built at three different times. In 1969 the main building was added to the east of the Mahnomen Hospital. It is 1-story, without a basement and is Type II(111) construction. In 1996 an addition to the north of the kitchen was added, is 1-story, no basement and Type II (111) construction, In 2000, additions of 1-story, without basements and of Type II(000) construction were built to the west of the 1969 building and to the north of the 1996 building, The 1969 building is separated by a 2-hour fire barrier from the Hospital building and from the 2000 east addition. The facility has 3 smoke compartments separated by at least 30 minute fire barriers. The facility is protected with an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING **01 - 1969 BUILDING WITH 1975 ADDITION** B. WING _____	**03/01/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	**414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 Systems with quick response heads. The facility has a fire alarm system with corridor smoke detection, sleeping room smoke detection, and smoke detection in common areas in accordance with NFPA 72 "The National Fire Alarm Code" . The facility has a capacity of 32 beds and had a census of 28 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72	K 341	Smoke detector in the East Wing Soiled Utility closet was moved to meet specifications.	3/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING **01 - 1969 BUILDING WITH 1975 ADDITION** B. WING _____	**03/01/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	**414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 341	Continued From page 3 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect an undetermined amount of patients, staff and visitors. Findings include: On the facility tour between 8:30 am to 11:30 am on 03/01/2018 observations revealed the smoke detector in the east wing soiled utility room was less than 36 inches from the HVAC return duct. This deficient condition was confirmed by the facility Operations Manager.	K 341		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain the smoke detection system as required by the Life Safety Code,(LSC) 2012 edition, section 9.6.2.10.1.1 and NFPA 72, The National Fire Alarm and Signaling Code, 2010 edition, section 29.10. This deficient condition could delay alarm notification in case of a fire and affect all 32 residents and an	K 345	The Facility Manager contacted SimplexGrinell (3rd Party Inspectors) to verify the number of devices. Number of devices will be confirmed at the next inspection due to be completed in May 2018.	3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING **01 - 1969 BUILDING WITH 1975 ADDITION** B. WING _____	**03/01/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	**414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 4 undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 am to 11:30 pm on 03/01/2018 record review revealed the current sensitivity inspection report did not have the same quantity of inspected devices as the previous year. No work was done to justify the difference. This deficient condition was confirmed by the facility Operations Manager.	K 345		
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview the facility failed to provide proof of training for all personnel that handle medical gas as required by NFPA 99 (12), the Health Care Facilities Code, section 11.5.2.1.1. This deficient condition could negatively affect an undetermined amount of residents and staff. Findings include: On the facility tour between 8:30 am to 11:30 pm	K 926	The Facility manager updated the oxygen safety policy on 3/20/2018 to include education of staff on the safe handling of medical gas. An education module has been created to deliver education on the safe handling of medical gas to educate all personnel who handle such gasses. Staff are to have this education complete by 4/30/2018. PRN and part-time staff will be educated on their next working shift. This education will be added to the annual	4/30/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245238	A. BUILDING **01 - 1969 BUILDING WITH 1975 ADDITION** B. WING _____	**03/01/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	**414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 926	Continued From page 5 on 03/01/2018 record review revealed there was no documentation to confirm that all staff that handle medical gas received the proper training. This deficient condition was confirmed by the facility Operations Manager.	K 926	requirements for all staff who handle medical gas.	