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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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

ID: XGSX

Facility ID: 00073

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245499**

2. STATE VENDOR OR MEDICAID NO.
(L2) **190176100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CALEDONIA CARE AND REHABILITATION CENTER**
(L4) **425 NORTH BADGER STREET**
(L5) **CALEDONIA, MN** (L6) **55921**

4. TYPE OF ACTION: **7** (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
8. Full Survey After Complaint
9. Other

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2004**

6. DATE OF SURVEY **11/12/2015** (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 **50** (L18)

13.Total Certified Beds 50 (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Marietta Lee, HFE NE II 11/13/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/13/2015 (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
**10/01/1987**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

*Protecting, Maintaining and Improving the Health of Minnesotans*

CMS Certification Number (CCN): 245499

November 13, 2015

Ms. Marian Rauk, Administrator
Caledonia Care And Rehabilitation Center
425 North Badger Street
Caledonia, MN 55921

Dear Ms. Rauk:

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

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

Effective November 3, 2015 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 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, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

*Protecting, Maintaining and Improving the Health of Minnesotans*

Electronically delivered

November 13, 2015

Ms. Marian Rauk, Administrator
Caledonia Care And Rehabilitation Center
425 North Badger Street
Caledonia, MN 55921

RE: Project Number S5499022

Dear Ms. Rauk:

On October 5, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 24, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On November 12, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 24, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 3, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 24, 2015, effective November 3, 2015 and therefore remedies outlined in our letter to you dated October 5, 2015, 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, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report

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

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245499 | A. Building<br>B. Wing | 11/12/2015 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| CALEDONIA CARE AND REHABILITATION CENTER | 425 NORTH BADGER STREET<br>CALEDONIA, MN 55921 |

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

| (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed |
|---|---|---|---|---|---|
| ID Prefix **F0272**<br>Reg. # **483.20(b)(1)**<br>LSC | **10/15/2015** | ID Prefix **F0282**<br>Reg. # **483.20(k)(3)(ii)**<br>LSC | **10/31/2015** | ID Prefix **F0309**<br>Reg. # **483.25**<br>LSC | **10/15/2015** |
| ID Prefix **F0315**<br>Reg. # **483.25(d)**<br>LSC | **11/03/2015** | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | GPN/kfd | 11/13/2015 | 15425 | 11/12/2015 |
| Reviewed By CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

**Followup to Survey Completed on:** 9/24/2015

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

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

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ID: XGSX
Facility ID: 00073

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2. STATE VENDOR OR MEDICAID NO. (L2) **190176100**

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(L4) **425 NORTH BADGER STREET**
(L5) **CALEDONIA, MN** (L6) **55921**

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) **07/01/2004**
6. DATE OF SURVEY **09/24/2015** (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 **50** (L18)

13.Total Certified Beds 50 (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Christina Smith, HFE NE II 10/15/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/09/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **10/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

*Protecting, Maintaining and Improving the Health of Minnesotans*

Electronically delivered
October 5, 2015

Ms. Marian Rauk,  Administrator
Caledonia Care And Rehabilitation Center
425 North Badger Street
Caledonia, Minnesota  55921

RE: Project Number S5499022

Dear Ms. Rauk:

On September 24, 2015, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required.  A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

**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**

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

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

**DEPARTMENT CONTACT**

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 3, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

**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.

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

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

• 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 December 24, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 24, 2016 (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 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. Gary Schroeder, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
gary.schroeder@state.mn.us
Telephone: (507) 361-6204

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245499 | A. BUILDING ______ B. WING ______ | 09/24/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CALEDONIA CARE AND REHABILITATION CENTER** | **425 NORTH BADGER STREET CALEDONIA, MN 55921** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 272 SS=D | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns;<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status; | F 272 | | 10/15/15 |

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

Electronically Signed — 10/15/2015

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 |
|---|---|---|---|
| | 245499 | A. BUILDING ______ B. WING ______ | 09/24/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **CALEDONIA CARE AND REHABILITATION CENTER** | **425 NORTH BADGER STREET CALEDONIA, MN 55921** |

| (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 272 | Continued From page 1<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment. | F 272 | | |
| | This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, facility failed to identify that a resident was on an antipsychotic when completing Admission Minimum Data Set for 1 of 5 residents (R20) reviewed for unnecessary medication.<br><br>Findings include:<br><br>R20's admission Minimal Data Set (MDS) dated 6/23/15, indicated R20 did not use antipsychotic medication in the last seven days. Also indicated R20 received assistance with activities of daily activity except with eating. R20's diagnosis from H&P (history and physical) dated 6/14/15, include but not limited to Asthma, Coronary artery disease, and depression.<br><br>Unlabeled Physician orders printed 9/24/15, indicated R20 was to receive "(Aripiprazole) [Brand name is Abilify an antipsychotic] 5 mg PO | | 1. R20's Abilify was entered as an antipsychotic on the next MDS. CAA's and care plan were corrected.<br>2. All other residents who are prescribed an antipsychotic had their CAAs and care plans reviewed and updated as needed.<br>3. Upon initiation/change/discontinuation of an antipsychotic, Social Services and the MDS Coordinator will be notified to make the needed follow through changes.<br>4. Monthly audits for three months and then quarterly on an on-going basis. This will be reported to the QAA Committee on a quarterly basis. | |

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| CALEDONIA CARE AND REHABILITATION CENTER | 425 NORTH BADGER STREET CALEDONIA, MN 55921 |

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| F 272 | Continued From page 2 | F 272 | | |

(by mouth) once daily HS (hour of sleep) (anxiety)." Order was started on 6/14/15.

On 9/24/15, at 10:18 a.m. registered nurse (RN)-A stated, [R20] did get abilify seven times during the admission MDS reference period. RN-A said, "It is not coded on admission MDS. It is not identified on CAA's (care area assessments). it should be part of the care plan."

According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated last revised on October 2014, the rationale for coding the antipsychotic medications are: "Medications are an integral part of the care provided to residents of nursing homes. They are administered to try to achieve various outcomes, such as curing an illness, diagnosing a disease or condition, arresting or slowing a disease's progress, reducing or eliminating symptoms, or preventing a disease or symptom. Residents taking medications in these medication categories and pharmacological classes are at risk of side effects that can adversely affect health, safety, and quality of life. While assuring that only those medications required to treat the resident's assessed condition are being used, it is important to assess the need to reduce these medications wherever possible and ensure that the medication is the most effective for the resident's assessed condition. As part of all medication management, it is important for the interdisciplinary team to consider non-pharmacological approaches. Educating the nursing home staff and providers about non-pharmacological approaches in addition to and/or in conjunction with the use of medication may minimize the need for medications or reduce the dose and duration of those medications."

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| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, facility failed to assist a resident to the bathroom in accordance with their care plan for 1 of 2 residents (R18) who were reviewed for urinary incontinence.<br><br>Findings include:<br><br>R18 had not been toiled for two hours and 39 minutes on 9/23/15 even though R18's care plan has an intervention to toilet very 2 hours or sooner.<br><br>During continuous observation on 9/23/15 from 7:00 a.m. to 9:39 a.m. R18 was not toileted in accordance with his care plan as follows:<br>9/23/15 at 7:00 a.m. R18 was observed sitting in wheelchair in lounge.<br>-7:11 a.m. Staff took R18 to the dining room.<br>-7:12 a.m. Restorative aide took R18 to restorative therapy room.<br>-7:55 a.m. Restorative aide brought R18 to the Dining room.<br>-8:07 a.m. R18 remains sitting at dining room table drinking coffee.<br>-8:23 a.m. Received breakfast tray and a cup of tea<br>-9:15 a.m. sitting in dining room.<br>-9:18 a.m. nursing assistant (NA)-B assisted res | F 282 | 1. To correct the deficiency for R18, we educated the nursing staff on the need to anticipate and follow the care plan for the toileting needs of the resident.<br>2. All residents care plans will be updated to provide current toileting needs by October 31.<br>3. Quarterly and with significant changes review and updates will be completed by the Interdisciplinary care planning team.<br>4. Audits of toileting/changing and repositioning will be performed by licensed staff and reported to the QAA Committee on a quarterly basis. Scheduled as follows: One time per week for one month and monthly thereafter. | 10/31/15 |

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| F 282 | Continued From page 4<br>to room. room clock says 930<br>-9:19 a.m. NA-B assisted R18 to the commode<br>-9:23 a.m. NA-B stated, "I am going to go finish some one else. " and left room<br>-9:30 a.m. NA-B returned "are you done yet?"<br>-9:30 a.m. NA-B left the room with resident sitting on commode still attached to EZ stand<br>-9:33 a.m. NA-B returned to room got supplies together<br>-9:35 a.m. NA-B assisted R18 to stand up using the EZ stand. Incontinence pad saturated with urine. Observed that R18 had two pads in place and the second pad was not wet. NA-B verified pad was soaked. Skin intake without redness.<br><br>R18's Care Plan printed 9/23/15 instructed staff to "toileting, Extensive assist, Assist of one with toileting every 2 hours and on demand."<br><br>R18's significant change Minimum Data Set (MDS) dated 4/8/15, indicated R18 was severely cognitively impaired and moderately depressed. R18 needed extensive assistance from staff with bed mobility transfers, toileting and personal hygiene. R18 was frequently incontinent of bowel and bladder. Physician progress note dated 7/1/15, indicated R18 had hypertension, chronic constipation and benign prostrate hyperplasia (enlarged prostrate).<br><br>Activities of daily living (ADL's) care area assessments (CAA) dated 4/17/15 indicated R18 requires extensive assist with ADLS such as extensive assist for ADLS. Urinary incontinence CAA indicated R18 receives daily diuretics causing urge incontinence and difficulty with ADLS causing functional incontinence.<br><br>CNA AM Assignment Sheet dated 9/22/15 | F 282 | | |

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| F 282 | Continued From page 5<br>instructed staff:<br>"SCHEDULED TOILETING Assist with toileting every 2 hours and assist on demand. Incontinent brief to be worn at all times. From 7/21/14<br><br>On 9/23/15, at 9:27 a.m. R18 stated, "I have not been to the bathroom since I got up and came out of the room."<br><br>During interview on 9/23/15, at 2:31 p.m. the director of nurses (DON) stated I would expect a resident to be toileted according to their care plan. I<br><br>Caledonia Care and Rehab Nursing Policy Incontinent/Toileting/Hydration review date 7/2015, instructs staff:<br>"...1. Caledonia Care and Rehab will do a comprehensive assessment upon admission to assure hydration and incontinence care/toileting is provided.<br>2. Based on the comprehensive assessment, each resident receives adequate fluids to maintain proper hydration and health.<br>3. based on the comprehensive assessment, each resident receives incontinent care. | F 282 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. | F 309 | | 10/15/15 |

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| F 309 | Continued From page 6<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to do a comprehensive skin assessment, or develop interventions to promote healing, prevent infection and prevent further skin tears to occur for 1 of 3 residents (R29) reviewed for non-pressure related skin issues.<br><br>Findings include:<br><br>R29 had been observed on 9/22/15, at 10:52 a.m., R29 was noted to have a dressing on her left forearm which was later determined to be covering a skin tear.<br><br>During an observation on 9/22/15 at 1:54 p.m., R29 was observed to be sitting in a recliner with the dressing on her left forearm. This was again observed at 9:52 a.m. On 9/23/15 at 8:34 a.m., R29 was being assisted by nursing assistant (NA)-A in her room and again there was a dressing on her left forearm.<br><br>R29's weekly skin assessment dated 9/16/15, stated that she had a skin tear on her left anterior forearm, no drainage noted. The note lacked any assessment of the skin tear nor did it contain any treatment/s. This was the only note found in the record of the skin tear and when asked for any information in regards to the skin tear none was provided.<br><br>R29's care plan, updated on 9/8/14, stated that R29 had some problems with skin tears. However, it did not contain any interventions if skin tears were to occur. | F 309 | 1. To correct the deficiency for R29 we educated the licensed staff on the need to use our standing orders for any skin tears found. R29's skin tear is healed.<br>2. CCR will identify other residents with skin tears and compare current treatments in the MAR to CCR's standing orders to assure proper treatment is being performed.<br>3. At CCR's weekly Incident/Accident Meeting a review of all Incident/Accidents will assure that appropriate follow through and treatment is provided.<br>4. Documentation of the weekly review by the DON/designee will provide audits of all Incident/Accidents. The information will be presented at the quarterly QAA Meetings. | |

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| F 309 | Continued From page 7 | F 309 | | |

When interviewed on 9/23/15 at 8:35 a.m., nursing assistant (NA)-A, stated that she noticed the dressing on R29's left forearm for the past week and a half. She stated that she reports bruising, swelling and skin tears to the nursing staff when they occur.

When interviewed on 9/23/15 at 11:21 a.m., licensed practical nurse (LPN)-A stated that she was not aware of a skin tear on R29's left forearm. She was not aware that she had a dressing placed on her left forearm.

When interviewed on 9/23/15, at 1:01 p.m., the director of nursing (DON) stated it would have been her hope to get a temporary care plan in place that would provide interventions for skin tears. She stated that there should have been an incident report. She stated that the nursing staff should have followed the standing orders for skin tears. They should have notified R29's physician as well as the family.

The facility's standing orders (initiated 2014), identified actions to be taken when skin tears were present. It stated the need to assess the resident and treat according to the listed protocol mentioned in the standing orders. It identified the need to reassess the wound during dressing changes and document wound healing weekly. It stated to assess for and attempt to reduce risk factors that may contribute to further problems. It indicated the need to inform the medical provider and family of open areas.

The facility's policy titled, Notification of Bruising and Skin Tears (no date), stated that the facility must notify the physician and the family of any skin tears. When a skin tear is found, an incident

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| F 309 | Continued From page 8<br>report is made out. | F 309 | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to provide assessed bladder services to prevent urinary tract infections, and maintain or restore as much bladder function as possible for 1 of 2 residents (R18) who were reviewed for urinary incontinence.<br><br>Findings include:<br><br>During continuous observation on 9/23/15 from 7:00 a.m. to 9:39 a.m. R18 was not toileted for two hours and 39 minutes even though they were assessed to need 2 hour incontinence/toileting checks as an intervention for bladder incontinence.<br>9/23/15 at 7:00 a.m. R18 was observed sitting in wheelchair in lounge.<br>-7:11 a.m. Staff took R18 to the dining room.<br>-7:12 a.m. Restorative aide took R18 to | F 315 | 1. Interdisciplinary Team reviewed our Incontinent Products and made changes according to individualized needs to provide dignity to our residents. Education will be provided to nursing staff to not leave alarmed resident unattended while using the E-Z Stand. Nursing staff were educated on the importance of following the care plan of each individual resident. Resident will be toileted according to stated care plan approach.<br>2. Interdisciplinary Team reviewed all residents for appropriate incontinent products. Educated the nursing staff on the safety of E-Z Stand usage for toileting needs.<br>3. Interdisciplinary Team will collaborate with the lead nursing assistant for appropriate product usage with a change in product needs and E-Z Stand usage. | 11/3/15 |

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| F 315 | Continued From page 9<br>restorative therapy room.<br>-7:55 a.m. Restorative aide brought R18 to the Dining room.<br>-8:07 a.m. R18 remains sitting at dining room table drinking coffee.<br>-8:23 a.m. Received breakfast tray and a cup of tea<br>-9:15 a.m. sitting in dining room.<br>-9:18 a.m. nursing assistant (NA)-B assisted res to room. room clock says 930<br>-9:19 a.m. NA-B assisted R18 to the commode<br>-9:23 a.m. NA-B stated, "I am going to go finish some one else. " and left room<br>-9:30 a.m. NA-B returned "are you done yet?"<br>-9:30 a.m. NA-B left the room with resident sitting on commode still attached to EZ stand<br>-9:33 a.m. NA-B returned to room got supplies together<br>-9:35 a.m. NA-B assisted R18 to stand up using the EZ stand. Incontinence pad saturated with urine. Observed that R18 had two pads in place and the second pad was not wet. NA-B verified pad was soaked. Skin intake without redness<br><br>R18's significant change Minimum Data Set (MDS) dated 4/8/15, indicated R18 was severely cognitively impaired and moderately depressed. R18 needed extensive assistance from staff with bed mobility transfers, toileting and personal hygiene. R18 was frequently incontinent of bowel and bladder. Physician progress note dated 7/1/15, indicated R18 had hypertension, chronic constipation and benign prostrate hyperplasia (enlarged prostrate).<br><br>Activities of daily living (ADL's) care area assessments (CAA) dated 4/17/15 indicated R18 requires extensive assist with ADLS such as extensive assist for ADLS. Urinary incontinence | F 315 | 4. DON/designee will round after breakfast and periodically to assure E-Z Stand usage is done per protocol. Interdisciplinary Team will communicate changes in resident product usage to Central Supply so appropriate ordering can occur. Kardex updates in medical record will provide information to nursing staff. | |

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| F 315 | Continued From page 10 | F 315 | | |

CAA indicated R18 receives daily diuretics causing urge incontinence and difficulty with ADLS causing functional incontinence.

Care Plan printed 9/23/15 instructed staff "toileting, Extensive assist Assist of one with toileting every 2 hours and on demand."

CNA AM Assignment Sheet dated 9/22/15 instructed staff:
"SCHEDULED TOILETING Assist with toileting every 2 hours and assist on demand. Incontinent brief to be worn at all times.--From 7/21/14
Other 6: Do not leave resident unattended when sitting on the toilet AM shift PM shift NOC shift--From 5/28/14
Other 1: Assist resident to transfer to toilet when observing resident attempting to do so independently AM shift PM shift NOC shift--From 11/06/13
Encourage sugar free fluids throughout the day. "

During interview on 9/23/15, at 9:12 a.m. licensed practical nurse (LPN)-B stated she thought [R18] was due at 9:17 a.m. The last time [R18] was toileted was not charted yet.

During interview on 9/23/1,5 at 9:45 a.m. NA-B said she had arrived at 6 a.m. and helped R18 with a.m. cares at 6:30 or 6:45 a.m. NA-B said R18 had been wet of urine but could not remember how wet. On asking NA-B toiling schedule for R18 she said every two hours. NA-B then said she have planned to take R18 to the commode around 9:30 p.m.

During interview on 9/23/15, at 11:27 a.m. LPN-A "[R18] is mainly incontinent of urine. [R18] will occasionally use urinal. We put [R18] on the

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| F 315 | Continued From page 11 | F 315 | | |

commode or toilet. I think [R18] is to be toilets every two to three hours. [R18] should be wearing one pad. Wearing more than one pad is a risk if you are doing a checking and changing the strips won't show [R18] is wet. Also the more pads there are will bother skin. Occasionally he knows when he needs [in regards to knowing he needs to urinate]. Staff can not leave [R18] unattended on a commode even if the EZ stand is in front of [R18].

During interview on 9/23/15, at 2:31 p.m. the director of nurses (DON) stated I would expect a resident to be toileted according to their care plan. I don't know about stacking incontinence pads on top of each other but I would not think they should use more than one at a time. On asking if R18 should be left alone when on commode, the DON said, "No" I would not expect them to leave him alone on the commode.

Caledonia Care and Rehab Nursing Policy Incontinent/Toileting/Hydration review date 7/2015, instructs staff:
"...1. Caledonia Care and Rehab will do a comprehensive assessment upon admission to assure hydration and incontinence care/toileting is provided.
2. Based on the comprehensive assessment, each resident receives adequate fluids to maintain proper hydration and health.
3. based on the comprehensive assessment, each resident receives incontinent care.

Printed: 09/28/2015

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

F5499024

FORM APPROVED
OMB NO. 0938-0391

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| | 245499 | A. BUILDING **01 - THE LUTHERAN HOME CALEDONIA**<br>B. WING ______ | **09/23/2015** |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on September 23, 2015. At the time of this survey, Caledonia Care and Rehab was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.<br><br>Caledonia Care and Rehab is a 1-story building. The building was constructed at 3 different times. The original building was constructed in 1961 and was determined to be of Type II(000)construction, with a full basement. In 1971, addition was constructed and was determined to be of Type II(000) construction, with no basement. In 1975, addition was constructed and was determined to be of Type II(000) construction, with no basement. Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.<br><br>The building is fully sprinklered The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.<br><br>The facility has a capacity of 50 beds and had a census of 44 at the time of the survey. | K 000 | | |

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

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.