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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XSU1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00313

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245410**
2.STATE VENDOR OR MEDICAID NO.
(L2) **585219600**

3. NAME AND ADDRESS OF FACILITY
(L3) **CARRIS HEALTH CARE CENTER & THERAPY SUITES**
(L4) **1801 WILLMAR AVENUE SOUTHWEST**
(L5) **WILLMAR, MN** (L6) **56201**

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) **01/01/2018**

6. DATE OF SURVEY **4/16/2018** (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)
12/31

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

12.Total Facility Beds **78** (L18)
13.Total Certified Beds **78** (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
	78			
(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 :
Brenda Fischer, Supervisor 04/18/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske, Enforcement Specialist 04/18/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1987
(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.
06201
(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): 245410
April 18, 2018

Ms. Pam Adam, Administrator
Carris Health Care Center & Therapy Suites
1801 Willmar Avenue Southwest
Willmar, MN 56201

Dear Ms. Adam:

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 1, 2018 the above facility is certified for:

78 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 78 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
April 18, 2018

Ms. Pam Adam, Administrator
Carris Health Care Center & Therapy Suites
1801 Willmar Avenue Southwest
Willmar, MN 56201

RE: Project Number S5410027

Dear Ms. Adam:

On March 13, 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 16, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 5, 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 1, 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 1, 2018 and therefore remedies outlined in our letter to you dated March 13, 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: XSU1

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(L5) **WILLMAR, MN** (L6) **56201**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2018**

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**
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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)
12/31

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

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13.Total Certified Beds **78** (L17)

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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)

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Bruce Melchert, HFE NE II 04/03/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Debby Baker, Enforcement Specialist 04/05/2018 (L20)

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

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

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01/01/1987
(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.
06201
(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 13, 2018

Ms. Pam Adam, Administrator
Carris Health Care Center & Therapy Suites
1801 Willmar Avenue Southwest
Willmar, MN 56201

RE: Project Number S5410027

Dear Ms. Adam:

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:

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

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

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

<u>Potential Consequences</u> - 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:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fischer@state.mn.us
Phone: (320) 223-7338
Fax: (320) 223-7348

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
	245410	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIS HEALTH CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 02/26/2018 through 03/01/2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On February 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 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose	F 561		3/16/18

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

Electronically Signed | 03/23/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIS HEALTH CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 561	Continued From page 1 activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a resident's preferences for shower frequency was honored for 1 of 1 resident (R45) who voiced concerns related to shower frequency. Findings include: R45's admission Minimum Data Set (MDS) dated 1/16/18, identified R45 had moderate cognitive impairment and required supervision while showering. The MDS identified choices in daily preferences were important to R45. The MDS indicated R45's diagnoses included cancer with metastasis (secondary cancer sites) and a seizure disorder, and also that R45 was receiving hospice services.	F 561	Corrective Action: Resident #45 was given option to have bath daily on 3/12/18 with the assistance of Hospice. Resident #45 was discharged from the facility on 3/15/18 to Belgrade Nursing Home based on resident request. Corrective Action Identify - Other Residents: All residents were asked what their bathing preference is. This was compared to current bathing schedule. Any resident that did not have their preference was given to the clinical coordinator to ensure bath schedule is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIS HEALTH CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 561	Continued From page 2 During observation on 2/26/18, at 2:33 p.m., R45 was well groomed, and seated in a wheelchair in her room. R45 placed her face in her hands and started crying. When interviewed on 2/26/18 at 2:33 p.m., R45 stated she was no longer able to do all her cares for herself and really wanted to take a shower on a daily basis as she felt unclean. Further, R45 stated told staff she wanted a shower daily, but was told she could not have one everyday. R45 stated hospice gave her a shower one time a week, and the facility provided a shower one time a week as well. R45's RCC (Rice Care Center) Resident Preferences, dated 1/11/18, identified R45 preferred a shower. The assessment did not identify how many showers a week R45 requested; however, listed a shower for Sunday and Wednesday in the morning. The undated facility bathing schedule identified R45 was scheduled for a shower on Thursdays, provided by the hospice agency, and Sundays, provided by the facility staff. During interview on 2/28/18, at 12:41 p.m. nursing assistant (NA)-D stated R45 received a shower twice a week, and added R45 had requested to have a shower daily. NA-D stated she was not sure why R45 was not showered daily, because the nurse manager made the bathing schedules. During interview on 2/28/18, at 1:22 p.m., licensed practical nurse (LPN)-A stated she "was aware" R45 would like a shower daily. LPN-A	F 561	adjusted to preference. A spreadsheet was created with all survey results for Quality Coordinator to monitor. Education was completed on 3/14/18 with care assistants and licensed staff on Cushman Cottage to ensure that when a resident requests bathing daily that the clinical coordinator is notified and it is documented on the residents bathing preference sheet on the front of their chart. Corrective Action to Prevent Reoccurrence: A bathing preferences policy was created. The purpose of the policy states: "To promote quality of life through bathing residents, according to their preferences." The Policy states: "It is the policy to accommodate each individual's bathing preferences." The Procedure states that bathing preferences will be asked and noted upon admission, readmission from hospital, and at care conferences. The bathing preferences will be accommodated according to resident wishes and staffing will be adjusted if needed to accommodate these preferences according to the policy. Education on new policy is being provided for all staff on all households at monthly meetings. Monitoring for Compliance: Bathing preferences will be reviewed for	

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F 561	Continued From page 3 stated it would be difficult to shower someone everyday, especially since there were many other residents that needed to be showered. During interview on 2/28/18, at 2:02 p.m. registered nurse (RN)-C stated R45 did tell her she wanted a shower daily, but thought R45 was scheduled for four showers a week between the facility and hospice. After reviewing the shower schedule, RN-C stated R45 was only receiving two showers a week, and she would work to increase R45's shower frequency. When interviewed on 3/1/18, at 1:50 p.m. the director of nursing stated residents should be showered "according to their preferences" and worked into the bathing schedule. The facility Patient Rights policy, dated 8/16, identified residents had the right to participate in decisions regarding their care.	F 561	each resident on admission and at the resident's care conferences. The residents bathing preference sheet will be updated for each resident according to his or her bathing preference, kept and uploaded into the EHR for each resident. The Quality Program Coordinator created a spreadsheet of resident survey results on bathing preference. The Quality Coordinator will audit by surveying 8 residents per month to ensure bathing preferences are met. Audits will be conducted for 3 months and results will be brought to QA Committee meeting. Completion Date: 3/16/18	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services	F 582		3/21/18

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F 582	Continued From page 4 specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 582	Corrective Action:	

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F 582	Continued From page 5 facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notices (SNFABN) for 2 of 3 residents (R25, R53) reviewed, whose Medicare A coverage ended and remained in the facility. Findings include: R25's face sheet, undated, indicated R25 was admitted 9/11/17, and was a current resident. R25's Notice of Medicare Non-Coverage (NOMNC) (CMS-10095) form, signed as received 10/16/17, indicated R25's skilled nursing services would end 10/18/17. R25's medical record was reviewed. The record lacked evidence a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) was provided to R25 to explain her financial liabilities, and opportunity to appeal the decision of non-coverage for R25, when Medicare no longer covered her stay. R53's face sheet, undated, indicated R53 was admitted on 10/26/17, and was a current resident. R53's Notice of Medicare Non-Coverage (CMS-10095) form, signed by the resident's representative as received 12/19/17, indicated R53's current skilled nursing services will end 12/21/17. R53's medical record was reviewed. The record lacked evidence a SNFABN was provided R25 to explain his financial liabilities and opportunity to appeal the decision of non-coverage for R53, when Medicare no longer covered his stay. When interviewed on 3/1/18 at 1:06 p.m., registered nurse (RN)-A stated residents who	F 582	A policy was completed regarding advanced beneficiary notice for residents who end Medicare Part A services but plan to remain in the facility. Corrective action to identify other residents: The administrator looked at all residents that were on Medicare in the last 12 months. Of the residents that did not receive an advanced beneficiary notice, the Administrator wrote a letter to the resident and/or resident representative and explained the error that they did not receive the notice. Those residents will be given the opportunity to complete the advanced beneficiary notice. Rice Care Center will follow the procedure based on the selection each resident or resident representative selected. Education was given to all clinical coordinators at QA Committee meeting on 3/20/18 in regards to completion of ABN form, instructions for use and new ABN form and instructions that is to be initiated in May, 2018 will be provided to all those that issue denials/ABNs. Corrective Action to Prevent Reoccurrence: Clinical Coordinators were given copy of the new SNFABN policy created on 3/19/18 and expressed and explained that they understand the process of completion of the forms.	

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F 582	Continued From page 6 come to the facility, get skilled services, and then end up staying at the facility "were not getting the SNFABN" notices as they should be. RN-A stated she routinely gave residents the "NOMNC" (Notice of Medicare Non-Coverage) form, but typically they were residents who went back home after their therapy ended, and didn't require any other notice. RN-A stated she was aware that residents, whose Medicare stay ended and remained in the facility, required both a generic notice (NOMNC) and the SNFABN form. RN-A stated "We don't have a process for it." When interviewed on 3/1/18 at 1:26 p.m., the director of nursing (DON) stated she was not aware residents were not getting the required notices. The DON stated the process needed "to be tightened up more" and we would be reviewing it. The DON also stated she would bring to the administrator's attention, make the changes, and get a policy made. A policy regarding advance beneficiary notice for residents was requested, but none was provided.	F 582	Monitoring for Compliance: Audits of medical records will be completed monthly for 6 months by the quality coordinator to assure compliance and that the forms were issued to those who were ending their Medicare Part A services but remaining in the facility. The audits will be reviewed and brought to QA Committee meeting.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 583		3/16/18

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F 583	Continued From page 7 §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain personal privacy for 2 of 2 residents (R12, R38) who had video monitoring devices in their rooms as an intervention to prevent falls which could be viewed by staff, visitors and other residents. Findings include: R12's diagnoses, as identified on a face sheet, undated. included anemia, and acute respiratory failure. The OBRA admission Minimum Data Set (MDS), dated 11/17/17, indicated R12 required the limited assistance of staff for bed mobility,	F 583	Corrective Action: Based on facility policy that "Patients/residents have the right to respectfulness and privacy as it relates to their medical and personal care, "All video monitoring systems have been removed from use in patient/resident rooms." A policy was created stating that no video monitoring systems, including cell phones, cameras, or any other video devices are permitted at Carris Health Care Center and Therapy Suites in resident/patient rooms.	

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transferring, ambulation, and most activities of daily living (ADLs). The MDS also indicated R12 had intact cognition.

R12's care plan, revised 12/5/17, identified R12 was at risk for falls, related to a history or urinary urgency, and narcotic medication use. The care also indicted R12 self transferred, and had impulse control issues. A care plan intervention to prevent falls for R12 directed: "Video monitoring in place r/t (related to) frequent self transfers without asking for help."

During observation on 2/26/18 at 6:50 p.m., R12 was dressed and lying in her bed, covered with a blanket and watching a game show on TV. R12 made no effort or attempt to exit the bed. A portable, remote camera device in R12's room, located near the corner of a dresser, below the TV, was pointed toward R12 as she lay in bed.

When interviewed on 2/26/18, at 3:28 p.m. R12 stated she has fallen in her room, and "stumbled" going to the bathroom. R12 stated she has not had any injuries from her falls. R12 stated she used a walker and got reminders from staff "all the time" about using her call light to request assistance to prevent falls. R12 said nothing about the video monitor in her room as an aid to prevent falls.

R38's diagnoses, as identified on a face sheet, undated, included Parkinson's disease, syncope (fainting) and dementia. The quarterly MDS, dated 1/9/18, indicated R38 required extensive assistance from staff for bed mobility, transferring, ambulation, locomotion and most ADLs, including toileting. The MDS also indicated

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R38 was cognitively impaired.

R38's care plan, dated 2/20/18, identified R38 was at risk for falls, had unstable balance, was impulsive in her actions, and required assistance of staff for all mobility. R38's care plan directed use of a video monitor: "Will be on resident when she is lying in bed so staff can see her in team room when she starts to move to get out of bed, and get to her quicker to reduce her fall risk."

During observation on 2/26/18 at 6:54 p.m., R38 was lying in her bed, asleep; the light above R38's bed was on. A portable, remote camera was on a counter, under the TV in R38's room, and the lens was pointing toward R38.

When interviewed on 2/26/18 at 6:55 p.m., nursing assistant (NA)-F stated both R38 and R12 had cameras in their rooms, which should be running, and they could be watched in the "Team room." NA-F stated the room where staff checked email and where resident charts were stored was called the "Team" room.

The nursing/chart or "Team" room was observed on 2/26/18, 6:57 p.m. in the Cushman Cottage unit was approximately 8' (feet) by 10' in size, and located across and east of the resident dining room. The room had windows on the north and west sides. The west window opened into the dining room and hallway, where other residents, visitors and staff could easily view inside the Team room. Inside the Team room were two, color video monitors, one for R38 and one for R12, which broadcasted the live activity of each resident from cameras in their rooms. The monitor screens were approximately 2" (inches) by 4", and R38's and R12's live video from their

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rooms could seen by anyone walking past and looking through the west window. The video monitor screens could also be seen through the Team room's south entry, which had no door. The Team room was in a common area where residents, visitors, and staff frequented throughout the day.

Continuing observation on 2/26/18, between 6:57 p.m. and 7:33 p.m., the video feeds, capturing R38's and R12's movements while they lay in bed, ran continuously. During this time, nursing staff were present in the area, intermittently walking past the Team room while completing evening routines. At 7:15 p.m., from inside the Team room, the surveyor observed R12 on the video monitor. R12 was laying in bed and taking a drink from a mug through a straw; a visitor was present in the room. At the same time, and on a different monitor, R38 also was also seen, in bed, asleep. At 7:20 p.m., a unidentified nursing assistant briefly entered the Team room, briefly glanced at the monitors, then pulled something from a cupboard and exited. When the surveyor exited the area at 7:33 p.m., the video feed from both R38's and R12's rooms continued, which could be seen by other residents, visitors whom walked past the west window of the Team room.

During intermittent observations on 2/27/18 between 8:17 a.m. and 10:45 a.m., there was live, continuous video feed from R38's and R12's rooms, which broadcast on the monitors in the Team room on the Cushman Cottage unit. R38 and R12 were visible in the monitors. During the observations, both R38 and R12 were and remained asleep in their rooms, in bed, and covered with blankets. Also, nursing assistants, a housekeeper, a visitor, homemaker staff, nurses,

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physical therapy staff, and hospice employees, all walked past the Team room, and its west window, allowing a glance into the room. Staff freely entered the room, sat at the counter in front of the video monitors, completed their work, then left. At times the Team room was unattended, but live video feed from R38's and R12's rooms ran continuously, and could be seen by anyone who looked into the Team room from the west window.

When interviewed on 2/28/17 at 1:25 p.m., nursing assistant (NA)-E stated the purpose of the video was because R12 and R38 were fall risks, and we want to allow them to be as independent as possible. NA-E stated when cares were performed, the cameras were to be covered, or turned away from the residents. NA-E stated the camera feed was visible from the 'Team' rooms, and that usually only nursing staff were in the room, but stated residents often go near and by the room.

When interviewed on 2/28/17 at 2:37 p.m., NA-G stated the video monitors were left on all the time, and during cares, the camera was to be turned "so nobody can see" during cares, because the feed was in the (Team) room. NA-G thought it "was possible" for people both in and out of the room to see the room monitors, because there was "a lot of traffic" going past outside the room, and you could see the screens through the window, from outside the Team room in the hallway. NA-G said the Team room was for staff, but stated she has seen families step into the room "to ask us a question."

When interviewed on 3/1/18 at 9:59 a.m., registered nurse (RN)-B stated over the years she considered use of video monitoring of

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residents for various reasons, but stated thought the practice to be "invasion of privacy" for residents. RN-B stated the use of a monitor did not replace staff. Additionally, RN-B stated if no one monitored the video, because staff were busy, it served little purpose. RN-B stated it was more a matter of luck if you saw and caught a resident trying to stand up or get out of bed on his own. RN-B also stated she would not want to see personal cares on a monitor in the Team room because "it's not just nursing staff" that use the team rooms. RN-B stated if the IT (information technology) person were in the room and watched cares this would be a "a privacy issue" for residents.

When interviewed on 3/1/18 at 11:15 a.m., registered nurse (RN)-C stated R12 and R38 each had video monitoring, and their use was as fall intervention strategies. RN-C stated the video monitor was "an extra tool" for staff to increase observation, and the practice had been in place for some time. RN-C stated when she worked the floor, she had successfully intervened to help residents because video monitoring was present. RN-C added when staff were busy, unavailable, or if no one was watching the video, the tool was ineffective. RN-C did not know of specific guidelines as to when the video monitors were to be on or turned off, but stated when staff were in the room providing cares, the cameras were turned away from the resident or covered. RN-C stated that since she has been in her role as a coordinator, she has "questioned" the use of the video "as far as it related to privacy" for residents. RN-C stated it has "crossed her mind" that just because something was used and had been in place, and was practiced, "I should not have assumed" that is was ok.

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F 583	Continued From page 13 When interviewed on 3/1/18 at 1:30 p.m., the director of nursing (DON) stated the purpose of most of the monitors was as a fall intervention, and stated before their use, we get "Okays" from families prior to their use. The DON stated the use of video monitoring "has been in place" for some time, but added, "that is not really an excuse" if it is a privacy issue. The DON was not aware a of a specific policy or guidelines for the use of video monitors. A facility policy, Patient Rights, revised 8/2016, indicated the facility "will establish mechanisms and processes to support" resident rights. The policy identified "Right to personal privacy and confidentiality" and indicated "Patients/residents have the right to respectfulness and privacy as it relates to their medical and personal care."	F 583		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and	F 645		3/21/18

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F 645	Continued From page 14 (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.	F 645		

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F 645	Continued From page 15 §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a level II pre-admission screen and resident review (PASRR) was completed for 1 of 1 residents (R50) reviewed who required a level II PASRR screening for mental illness. Findings include: R50's diagnoses, as identified on the Resident Face Sheet (undated), included schizoaffective disorder, major depressive disorder, and anxiety disorder. The face sheet indicated R50 was admitted to the facility on 1/11/18. R50 was receiving treatment for post fall left hip fracture, which occurred in his group home. During observation and interview with R50, on 2/26/18, at 1:25 p.m., R50 stated he did not leave his room much while he was "sore and all broken up." He does go to meal and visits with the other men on the unit, but otherwise he watches TV in his room. R50 further indicated he was more active than he is now, giving the examples of winning 7 black belts, world class events in martial arts, being a star in MMA (Mixed martial arts) for the past five years and being in the	F 645	Corrective Action: #R50's County Social Worker was contacted by Carris Health Care Center and Therapy Suites' Social Worker and it was found that resident's screening was completed incorrectly from the county worker. The form was changed that R50 did NOT require a level 2 screening. The form was corrected on 3/2/18 and submitted to surveyor at the time of the survey on 3/5/18. Corrective Action-Identify Other Residents: Clinical Coordinators reviewed all residents to determine if they required level 2 screening. The county was called on those residents that did not have a level 1 screening on record. These residents have resided at Carris Health Care Center and Therapy Suites for a long time. All residents have been reviewed and determined no level 2 screenings are needed.	

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F 645	Continued From page 16 secret service. R50 stated he slipped on oil that was under some ice at his group home, and broke his left hip, left knee and "both the bones in my ankle." R50's medical record was reviewed. R50's record contained an OBRA, Level I, Criteria-Screening for Developmental Disabilities or Mental Illness, dated 4/10/17. The document, as completed, indicated R50 did have a major, mental illness. The document was of poor quality Fax from Kandiyohi County, and marked as having "no change" for this admission. R50's medical record did not contain a Level 2 pre-admission screen. During interview on 3/01/18 at 9:29 a.m., the unit case manager (RN)-A and the master social work (MSW)-A, stated that they were unaware R50 needed a level 2 screening. RN-A and MSW both stated the county case manager was in the facility 1 day before the 30 day time frame, when a Level II is required to complete for residents with mental illness and developmental disabilities. The group home where R50 resided previously denied R50 readmission. RN-A and MSW assumed the county case manger would have recognized the need to complete a Level II screen, both this was not completed. R50's county case manager was contacted, but not available. A facility policy for pre-admission screening and resident review (PASRR) was requested but not provided.	F 645	The form used by the county was in small print and illegible. Carris Health Care Center and Therapy Suites informed the county that we will not accept a document we cannot read or determine legibility. The actual level 2 screening form will be sent. The Carris Health Care Center and Therapy Suites will ensure all residents requiring a level 2 screening will receive one. This is indicated on our current policy and procedure and it is also indicated on the Social Service Assessment. Corrective Action to Prevent Reoccurrence: Social Services will follow the PASARR screening questions located in the Mood and Behavior Policy and Procedure and the Social Services Assessment. The Social Worker and Admission Coordinator will ensure all admission screenings level 1 will be completed on admission. If level 2 is triggered, will assure proper documentation is received prior to admission. Monitoring for Compliance: Social Services called the county and requested that this facility receives legible documentation that a level 2 screening is required for admits that requires this level of screening. Social Services will ensure compliance of the F-tag by requesting that documentation from the county for level 2 screenings is received. Once received, it is transferred to Health Information	

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F 645	Continued From page 17	F 645	Systems and scanned to the medical record. Health Information Systems will monitor the process by completing a double check to ensure a level 2 has been completed. Any discrepancies will be reported to social services for further follow up. Results of this monitoring will be reviewed at QA.	
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a follow-up appointment was scheduled to evaluate the fit and function of recently-dispensed eye glasses for 1 of 1 resident (R13) reviewed for vision. Findings include: R13's quarterly Minimum Data Set dated 12/4/17, indicated R13 had visual impairment, but was able to read large print. The MDS also indicated R13 had intact cognition and was able to	F 685	Corrective Action: #R13 was scheduled for eye doctor appointments on 3/5 and 3/7 to make sure eyeglasses fit resident appropriately. Corrective Action - Identify Other Residents All residents were audited to determine if they were having problems with their vision, had glasses, fitting appropriately,	3/19/18

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F 685	Continued From page 18 communicate her needs. R13's diagnoses included diabetes R13's care plan, revised 12/13/17, identified impaired vision, chronic dry eye, and that R13 was diagnosed with macular degeneration of the left eye. The care plan directed staff to make sure glasses were clean and in good repair. During observation on 2/26/18, at 3:12 p.m., R13 was wearing her glasses, but was holding her glassess tilted, with one side higher than the other, while she completed a word-find puzzle. R13's glasses were held at approximately a 15 degree angle higher than the other side of the glasses. When interviewed on 2/26/18 at 3:12 p.m., R13 stated she had recently got new glasses, but they did not fit well. R13 stated the new glasses didn't fit "with the line of vision" and it was necessary for her to tilt her glasses on her face in order to read well. R13 stated she enjoyed doing large print word find puzzles, but it was difficult to do so now because she had to tilt her glasses in order to see through them and read. R13 stated she told staff of her concern "approximately two weeks ago," but had not heard anything in follow up. A facility Referral Form dated 12/13/17, indicated R13 was seen for a diabetic eye exam, a check for dry eye syndrome, and macular degeneration of the left eye. R13's orders indicated: new glasses; make sure lighting is adequate for reading; artificial tears twice daily for dry eyes; and follow up yearly. A Referral Form dated 1/19/18, indicated new glasses were placed on order for R13, with anticipated arrival in seven to ten days; R13 received her new glasses.	F 685	and if they had vision concerns. Any resident that identified concerns were communicated to the Clinical Coordinator. Vision appointments were made for those residents. Vision, hearing, and dental needs will be discussed at resident care conferences. The Care Conference Policy and Procedure was updated to include vision, hearing and dental needs. Corrective Action to Prevent Reoccurrence: A spreadsheet was put in place for residents on 3/19/18 that lists out the dates of residents last eye, dental, and hearing appointments. The spreadsheet will be looked at prior to every residents quarterly care conference and the last appointment will be discussed, if the resident has not had one yearly, one will be offered and scheduled accordingly. All appointments will be documented in the spreadsheet and accessible to the Clinical Coordinators and Health Information Specialists for making appointments. If the resident receives new eyeglasses, the Clinical Coordinator will check in with the resident to ensure that the eye glasses are fitting correctly within 5 to 7 days of the resident getting the glasses. If the glasses are found to not be fitting appropriately or if the resident has any concerns regarding the new glasses, the Clinical Coordinator and/or Health Information Specialist will make a follow up appointment for the resident and make	

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F 685	Continued From page 19 During interview on 2/28/18, at 2:14 p.m., household coordinator (HC)-A stated R13 had informed her about two weeks ago of problems with proper eyeglass fit, but was unable to recall specific date. HC-A stated she had not documented this in follow up. HC-A stated she informed support staff of R13's issue, requested an appointment be scheduled, but stated she did not follow up to see if this was complete. HC-A stated R13 approached her today to inquire of status. HC-A stated she would expect follow-up would occur within one to three days of the request. When interviewed on 3/1/18 at 10:42 a.m., registered nurse (RN)-B stated HC-A had requested a follow up regarding R13's new eyeglasses. RN-B stated when a concern was identified by a resident, she would expect this would have been documented in the electronic record, with interventions, and also included as to the follow through. RN-B stated visual status was assessed quarterly with MDS completion and care conferences. RN-B also stated a routine, annual visit was offered and coordinated, as desired by resident. A facility policy regarding resident assessment for vision and coordination of appointments was requested, but none was provided.	F 685	sure each appointment is documented in the spreadsheet. Monitoring for Compliance: The Health Information Specialist will be able to check each residents chart prior to their scheduled care conferences. Each resident is required to have a quarterly care conference and therefore each resident will be checked for vision, hearing and dental appointments four times a year. The Quality Coordinator will audit the spreadsheet monthly for 6 months to monitor compliance. All results of the audits will be reviewed in QA.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-	F 686		3/21/18

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F 686	Continued From page 20 (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely repositioning was offered for 1 of 1 residents (R28) reviewed who had facility acquired pressure ulcers and was at risk for further development of pressure ulcers. Findings include: R28's quarterly Minimum Data Set (MDS) dated 1/3/18, identified R28 had severe cognitive impairment and required extensive assistance for bed mobility and transfer assistance. A diagnosis of dementia was identified. The MDS identified R28 was at risk to develop pressure ulcers, but currently had no unhealed pressure ulcers. R28's pressure ulcer Care Area Assessment (CAA) dated 6/27/17, identified R28 was at risk to develop pressure ulcers. R28 received extensive assistance with bed mobility, locomotion and transfers. R28 had a history of pressure ulcers, but currently had no pressure ulcers and her skin was intact. R28 was non-compliant with repositioning and would only reposition when she needed to use the bathroom. Additional risk factors were identified as incontinence, edema of the lower extremities and severe cognitive deficit.	F 686	Corrective Action: The Cushman Cottage Clinical Coordinator implemented an assigned repositioning schedule. Each nursing assistant has specific residents assigned to them each shift for which they are responsible to make sure that the resident's repositioning is completed in compliance with their care plan. In addition, each repositioning is charted on the brain board daily care log sheet. Corrective Action-Identify Other Residents: Residents on Cushman Cottage that are on a repositioning schedule will be assigned on the brain board daily log sheet kept in the team room on Cushman Cottage that all staff have access to starting on 3/19/18. Corrective Action to Prevent Reoccurrence: The repositioning will now be completed	

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F 686	Continued From page 21 R28's skin care plan dated 1/25/18, included interventions of repositioning every two hours and to reproach if she refused, pressure relieving boots and a pressure reducing wheelchair cushion. During continuous observation on 2/28/18, at 6:56 a.m. to 10:15 a.m., R28 was provided morning cares by nursing assistant (NA)-E at 6:56 a.m. R28 had black pressure relieving boots to both feet. When the boots were removed a white dressing was in place to both heels, the dressings were clean and intact.. NA-E stated R28 had pressure ulcers on both heals so she needed to wear pressure reducing boots. After looking at R28's feet, NA-E replaced the black pressure reducing boots on R28's feet. At 7:20 a.m. R28 was transferred to her wheelchair with a standing lift and brought to the dining room by NA-E. She remained in the dining room until 8:58 a.m. when she finished her breakfast meal. NA-D wheeled R28 to the living room area and but on music for R28. NA-D did not reposition or offer R28 any repositioning. R28 remained in her wheelchair until 9:48 a.m. when she started to use her feet and pushed herself backwards down the hall from the living room. R28 started calling out quietly "up, up, up." There was no staff in the hallway. It had been 2 hours and 28 minutes since R28 had been placed in her wheelchair and last repositioned. At 9:51 a.m. NA-H walked past R28 as she was seated in her wheelchair in the hallway saying "up, up, up." NA-H continued down the hall and made no attempts to assist R28 with	F 686	by assigning staff to be responsible for the repositioning needs for specific residents. Staff education was performed using various modalities: in person, at morning huddles on 3/16, 3/19, and 3/20 and via email. The nurse that is assigned to the medication cart on Cushman Cottage every shift is responsible for ensuring the compliance of the brain board daily log sheet documentation. The quality Coordinator will monitor for documentation compliance. Monitoring for compliance: Documentation audits will be performed by the quality coordinator weekly for four weeks starting on 3/19/18 and then monthly for 3 months to ensure compliance is being met. Audit results will be brought to QA Committee meeting for review.	

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repositioning. At 9:53 a.m. the activity director (AD)-A stopped and talked with R28 and asked if she was good. R28 replied she was not sick. The AD-A tried to engage R28 with an activity but R28 continued to repeat she was not sick. At 9:59 a.m. AD-A wheeled R28 to the dining room table so licensed practical nurse (LPN)-A could administer her medications.

At 10:07 a.m. LPN-A finished administering medications to R28 and asked her if she needed to use the bathroom. R28 did not respond. LPN-A started wheeling R28 down the hall towards her room when R28 put her feet down and told LPN-A, "No", she was not sick. LPN-A attempted to talk R28 into going to her room to reposition and use the bathroom.

At 10:13 a.m. NA-D approached R28 and asked her if she needed to go to the bathroom. R28 agreed to go to her room. At 10:15 a.m. NA-D transferred R28 out of her wheelchair with a standing lift. It had been 2 hours and 55 minutes since R28 was last repositioned. R28's buttocks was pink which faded quickly after standing and her skin was intact with no pressure ulcers.

During interview on 2/28/18, at 10:15 a.m. NA-D stated R28 was supposed to be repositioned every two hours and she was late repositioning her. Further, she did not offer to reposition R28 following breakfast because she had not been up for two hours at that time.

R28's Tissue Tolerance Assessment (frequency of positioning assessment) dated 1/1/18, identified R28 required a two hour repositioning schedule. R28's Braden Scale (assessment for risk of pressure ulcer development) dated

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1/25/18, identified R28 was at risk to develop pressure ulcers.

R28's Weekly Wound Documentation Progress Sheet dated 1/31/18, identified two Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister.) pressure ulcers , one on each heel. The left heel measured 3.5 centimeters (cm) by 1.5 cm's and presented as raised and fluid filled. The right heel measured 3 cm by 5.5 cm and presented as raised and fluid filled. The pressure ulcers were assessed weekly and R28 continued with the pressure ulcers on the last weekly documentation of 2/27/18. Both pressure ulcers were documented as showing improvement on 2/27/18.

On 2/28/18, at 1:09 p.m. LPN-A stated R28's repositioning was about an hour late today because she got up an hour earlier than usual and was just missed. LPN-A stated the wound care nurse placed new dressing to each of R28's heals yesterday and the dressings were to remain in place for one week and only changed if there was any saturation greater than 50 percent.

When interviewed on 3/1/18, at 1:00 p.m. registered nurse (RN)-C stated R28 was at risk to develop more pressure ulcers related her inability to reposition herself and poor nutrition. R28 should have been repositioned according to her care plan to prevent the development of pressure ulcers.

On 3/1/18, at 1:40 p.m. the director of nursing stated her expectation was for residents to be repositioned within their assessed time frame if

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F 686	Continued From page 24 not sooner. The facility policy Skin Care dated 7/17, identified preventative measures for pressure ulcers included a repositioning schedule and resident who cannot move themselves needed to be repositioned as assessed.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal	F 690		3/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIS HEALTH CARE CENTER & THERAPY SUITES	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

(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 690	Continued From page 25 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess a resident for bladder incontinence care for 1 of 1 residents (R31) reviewed for post-catheter removal voiding needs. Findings include: R31's diagnoses as identified on the Resident Face Sheet, undated, included cerebral infarction (stroke), left sided hemiparesis (muscular weakness or partial paralysis restricted to one side of the body), and cognitive function and awareness being affected. R31's Admission Minimum Data Set (MDS), dated 12/25/17, indicated R31 was minimally, cognitively impaired, received extensive assistance with 2 staff for activities of daily living (ADLs), and had an indwelling Foley catheter. R31's care area assessment (CAA) for Urinary Incontinence / Indwelling Catheter, dated 12/25/17, unsigned, identified R51 was admitted with a Foley catheter and would be trailed without within 5 weeks. R31's physician's admission orders (dated 12/19/17), identified R31's catheter orders were clarified to: "Foley Order - for 5 more weeks then trial off [and] see if retention persists." R31's TENA/SCA Bladder Assessment (dated 12/23/17 and unsigned), indicated R31 was	F 690	Corrective Action: The insertion of an indwelling catheter policy and procedure was updated to include removal of the indwelling catheter, charting and assessment to be completed after an indwelling catheter removal, and circumstances of when to complete a bladder scan or straight catheterization. Corrective Action -Identify Other Residents Any resident admitted with a Foley catheter or that has one placed from 3/21/18 and on, will follow the developed policy and procedure for discontinuation of the Foley and post void residual monitoring. There are currently no other residents facility wide with Foley's in place as of 3/21/18. Corrective Action to Prevent Reoccurrence: The policy now includes the procedure for removing an indwelling catheter. Also included: 1. when an indwelling catheter is removed, a 3-day bowel and bladder diary must be completed. 2. a bowel and bladder assessment on day 4 after	

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F 690	Continued From page 26 continent of bladder, however had an indwelling catheter due to "Untreatable Urethral Blockage Causing Urinary Retention." R31's nursing progress notes, dated 01/16/2018 indicate, "Foley discontinued as per orders. Pt [patient] tolerated procedure fairly. Scant amount of red blood noted from penis after Foley was pulled. Bladder scanned for 289 ml [milliliters]. No urge to void at this time." Although R31 was able to tolerate removal of the urinary catheter on 1/16/18, the facility did not comprehensive reassessment R31's toileting needs, urinary frequency, pattern or assistance to maintain his bladder function at the highest level, after the Foley catheter had been removed. R31's Care Plan, last revised 2/22/18, indicated a history of urine retention resulting Foley catheter placement at prior to facility admission due to urinary retention which had been discontinued on 1/16/18, and directed staff to: "Assist with use of urinal. Check with him with each interaction on need to void." During interview on 2/28/18 9:26 a.m., nursing assistant (NA)-A stated R31 was dry and was offered toileting upon rising, before and after each meal and at bed time, or if the resident requests. NA-A stated R31 was independent with his urinal if left within reach, but they change his soiled incontinent product 1-2 times a day. During further observation on 2/28/18 at 2:00 p.m., NA-B and NA-C, had just left R31's room after answering the call light, when R31 wanted to go back to bed. NA-B and NA-C both stated they checked R31's incontinent product, which was	F 690	removal of the catheter must be completed, and 3. the facility's standing orders for bladder scanning and straight catheterization of residents PRN. Monitoring for compliance: The Clinical Coordinator of the household will ensure that the diary and the assessment have been completed after the catheter is removed and will implement further interventions as needed. The Quality Coordinator RN will audit 100% of residents that have Foley catheters in place to ensure compliance for a period of 1 year, after that the need for further auditing will be determined. Results of the audits will be reviewed in QA.	

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F 690	Continued From page 27	F 690		

dry. Both staff members stated that R31 did not wish to use the bathroom or urinal at that time. NA-B stated the resident was routinely wet upon rising and may have to be changed throughout the day, either due to urinary incontinence or spilling the urinal on himself. NA-B and NA-C both stated R31 toileting plan was to toilet upon rising, before and after each meal and at bed time, or if resident requests. .

During interview on 3/1/17 at 10:30 a.m., the unit care manager registered nurse (RN)-A stated the facility needed to reassessed R31's toileting needs using a 3 day bladder log to determine a voiding pattern, and a time frame to assist with toileting. A reassessment of R31's toileting needs were not completed after removal of the indwelling catheter.

The facility policy, Bowel and Bladder Incontinence, revised 07/2017, indicted the following: "A resident who is incontinent of bowel and bladder receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. No Foley Catheter will be in place without documentation of clinic condition/necessary." The policy did not indicate what assessment should be done when a catheter was removed.

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	245410	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIS HEALTH CARE CENTER & THERAPY SUITES	**1801 WILLMAR AVENUE SOUTHWEST** **WILLMAR, MN 56201**

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Carris Health Care Center, was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/23/2018

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.

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K 000	Continued From page 1 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or 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. Carris Health Care Center is a 1-story building with no basement that was constructed at 6 different times. The original building was constructed in 1965 and was determined to be of Type II(111) construction. In 1995, an addition was constructed on the south side of the original building and was determined to be of Type II(111) construction. Since the original building and the 1995 addition are both Type II (111) construction they were both inspected as buildings under Existing Healthcare requirements. The first addition was built in 2011, and is a 1-story addition without a basement that is located on the south side and was determined to be of Type V(111) construction. The second addition was built in 2012, and is a 1-story addition without a basement that is located on the south side of the northeast wing of and was determined to be of	K 000		

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K 000	Continued From page 2 Type V(111) construction. The third addition was built in 2013, and is a 1-story addition without a basement that is located on the south side of the northwest wing and was determined to be of Type V(111) construction. The fourth addition to the facility consisted of two building that were both built in 2014, both additions are 1-story additions without basements that are located on the west side of the 2011 addition. It was determined that both 2014 additions are of Type V(111) construction. Surveyed as one building. The facility is equipped with a fire alarm system that has smoke detection in the corridors and in spaces that are open to the corridors, and that is monitored for automatic fire department notification. The facility is fully protected by an automatic fire sprinkler system. At the time of the inspection the facility has a capacity of 78 beds and had a census of 64. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced	K 901		3/19/18

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K 901	Continued From page 3 by: Based on documentation review and staff interview, the facility failed to inspect the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. The deficient practice could affect all 78 residents. Findings include: During documentation review between 9:30 AM and 1:00 PM on 02/27/2018, documentation review and staff interview revealed the required risk assessment NFPA 99 had not been started at the time of the survey. This deficient condition was confirmed by the Director of Maintenance.	K 901	The risk assessment NFPA 99 2012 Chapter 4 was completed on 3/19/18. Mike Whelan, Maintenance/Biomed responsible to ensure compliance.	
K 912 SS=E	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Electrical Systems - Receptacles Power receptacles have at least one, separate,	K 912	Outlets in patient care areas and critical outlets will be inspected annually.	4/1/18

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K 912	Continued From page 4 highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.4.2 (NFPA 99) This deficient practice could affect 78 of 78 residents. Findings include: During documentation review on 02/27/2018, documentation could not be located to show that an electrical outlet inspection had occurred throughout the facility. This deficient condition was confirmed by the Director of Maintenance.	K 912	Referenced NFPA 99 2012 Chapter 6.3.4 Mike Whelan, Maintenance/Biomed Manager responsible to ensure compliance.	

Electronically delivered
March 13, 2018

Ms. Pam Adam, Administrator
Carris Health Care Center & Therapy Suites
1801 Willmar Avenue Southwest
Willmar, MN 56201

Re: State Nursing Home Licensing Orders - Project Number S5410027

Dear Ms. Adam:

The above facility was surveyed on February 26, 2018 through March 1, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer at (320) 223-7338 or brenda.fischer@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

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
	00313	A. BUILDING: _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIS HEALTH CARE CENTER & THERAPY S	1801 WILLMAR AVENUE SOUTHWEST WILLMAR, MN 56201

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On February 26-28, and March 1, 2018, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely repositioning was offered for 1 of 1 residents (R28) reviewed who had facility acquired pressure ulcers and was at risk for further development of pressure ulcers. Findings include: R28's quarterly Minimum Data Set (MDS) dated 1/3/18, identified R28 had severe cognitive impairment and required extensive assistance for	2 900	Corrected	3/21/18

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2 900	Continued From page 3	2 900		

bed mobility and transfer assistance. A diagnosis of dementia was identified. The MDS identified R28 was at risk to develop pressure ulcers, but currently had no unhealed pressure ulcers. R28's pressure ulcer Care Area Assessment (CAA) dated 6/27/17, identified R28 was at risk to develop pressure ulcers. R28 received extensive assistance with bed mobility, locomotion and transfers. R28 had a history of pressure ulcers, but currently had no pressure ulcers and her skin was intact. R28 was non-compliant with repositioning and would only reposition when she needed to use the bathroom. Additional risk factors were identified as incontinence, edema of the lower extremities and severe cognitive deficit.

R28's skin care plan dated 1/25/18, included interventions of repositioning every two hours and to reproach if she refused, pressure relieving boots and a pressure reducing wheelchair cushion.

During continuous observation on 2/28/18, at 6:56 a.m. to 10:15 a.m., R28 was provided morning cares by nursing assistant (NA)-E at 6:56 a.m. R28 had black pressure relieving boots to both feet. When the boots were removed a white dressing was in place to both heels, the dressings were clean and intact.. NA-E stated R28 had pressure ulcers on both heals so she needed to wear pressure reducing boots. After looking at R28's feet, NA-E replaced the black pressure reducing boots on R28's feet.

At 7:20 a.m. R28 was transferred to her wheelchair with a standing lift and brought to the dining room by NA-E. She remained in the dining room until 8:58 a.m. when she finished her breakfast meal. NA-D wheeled R28 to the living

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2 900	Continued From page 4	2 900		

room area and but on music for R28. NA-D did not reposition or offer R28 any repositioning. R28 remained in her wheelchair until 9:48 a.m. when she started to use her feet and pushed herself backwards down the hall from the living room. R28 started calling out quietly "up, up, up." There was no staff in the hallway. It had been 2 hours and 28 minutes since R28 had been placed in her wheelchair and last repositioned.

At 9:51 a.m. NA-H walked past R28 as she was seated in her wheelchair in the hallway saying "up, up, up." NA-H continued down the hall and made no attempts to assist R28 with repositioning. At 9:53 a.m. the activity director (AD)-A stopped and talked with R28 and asked if she was good. R28 replied she was not sick. The AD-A tried to engage R28 with an activity but R28 continued to repeat she was not sick. At 9:59 a.m. AD-A wheeled R28 to the dining room table so licensed practical nurse (LPN)-A could administer her medications.

At 10:07 a.m. LPN-A finished administering medications to R28 and asked her if she needed to use the bathroom. R28 did not respond. LPN-A started wheeling R28 down the hall towards her room when R28 put her feet down and told LPN-A, "No", she was not sick. LPN-A attempted to talk R28 into going to her room to reposition and use the bathroom.

At 10:13 a.m. NA-D approached R28 and asked her if she needed to go to the bathroom. R28 agreed to go to her room. At 10:15 a.m. NA-D transferred R28 out of her wheelchair with a standing lift. It had been 2 hours and 55 minutes since R28 was last repositioned. R28's buttocks was pink which faded quickly after standing and her skin was intact with no pressure ulcers.

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2 900	Continued From page 5 During interview on 2/28/18, at 10:15 a.m. NA-D stated R28 was supposed to be repositioned every two hours and she was late repositioning her. Further, she did not offer to reposition R28 following breakfast because she had not been up for two hours at that time. R28's Tissue Tolerance Assessment (frequency of positioning assessment) dated 1/1/18, identified R28 required a two hour repositioning schedule. R28's Braden Scale (assessment for risk of pressure ulcer development) dated 1/25/18, identified R28 was at risk to develop pressure ulcers. R28's Weekly Wound Documentation Progress Sheet dated 1/31/18, identified two Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister.) pressure ulcers , one on each heel. The left heel measured 3.5 centimeters (cm) by 1.5 cm's and presented as raised and fluid filled. The right heel measured 3 cm by 5.5 cm and presented as raised and fluid filled. The pressure ulcers were assessed weekly and R28 continued with the pressure ulcers on the last weekly documentation of 2/27/18. Both pressure ulcers were documented as showing improvement on 2/27/18. On 2/28/18, at 1:09 p.m. LPN-A stated R28's repositioning was about an hour late today because she got up an hour earlier than usual and was just missed. LPN-A stated the wound care nurse placed new dressing to each of R28's heals yesterday and the dressings were to remain in place for one week and only changed if there was any saturation greater than 50 percent.	2 900		

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2 900	Continued From page 6 When interviewed on 3/1/18, at 1:00 p.m. registered nurse (RN)-C stated R28 was at risk to develop more pressure ulcers related her inability to reposition herself and poor nutrition. R28 should have been repositioned according to her care plan to prevent the development of pressure ulcers. On 3/1/18, at 1:40 p.m. the director of nursing stated her expectation was for residents to be repositioned within their assessed time frame if not sooner. The facility policy Skin Care dated 7/17, identified preventative measures for pressure ulcers included a repositioning schedule and resident who cannot move themselves needed to be repositioned as assessed. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence	2 910		3/16/18

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2 910	Continued From page 7 Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. 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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess a resident for bladder incontinence care for 1 of 1 residents (R31) reviewed for post-catheter removal voiding needs. Findings include: R31's diagnoses as identified on the Resident Face Sheet, undated, included cerebral infarction (stroke), left sided hemiparesis (muscular weakness or partial paralysis restricted to one side of the body), and cognitive function and awareness being affected. R31's Admission Minimum Data Set (MDS), dated 12/25/17, indicated R31 was minimally, cognitively impaired, received extensive assistance with 2 staff for activities of daily living (ADLs), and had an indwelling Foley catheter. R31's care area assessment (CAA) for Urinary Incontinence /	2 910	Corrected	

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2 910	Continued From page 8 Indwelling Catheter, dated 12/25/17, unsigned, identified R51 was admitted with a Foley catheter and would be trailed without within 5 weeks. R31's physician's admission orders (dated 12/19/17), identified R31's catheter orders were clarified to: "Foley Order - for 5 more weeks then trial off [and] see if retention persists." R31's TENA/SCA Bladder Assessment (dated 12/23/17 and unsigned), indicated R31 was continent of bladder, however had an indwelling catheter due to "Untreatable Urethral Blockage Causing Urinary Retention." R31's nursing progress notes, dated 01/16/2018 indicate, "Foley discontinued as per orders. Pt [patient] tolerated procedure fairly. Scant amount of red blood noted from penis after Foley was pulled. Bladder scanned for 289 ml [milliliters]. No urge to void at this time." Although R31 was able to tolerate removal of the urinary catheter on 1/16/18, the facility did not comprehensive reassessment R31's toileting needs, urinary frequency, pattern or assistance to maintain his bladder function at the highest level, after the Foley catheter had been removed. R31's Care Plan, last revised 2/22/18, indicated a history of urine retention resulting Foley catheter placement at prior to facility admission due to urinary retention which had been discontinued on 1/16/18, and directed staff to: "Assist with use of urinal. Check with him with each interaction on need to void." During interview on 2/28/18 9:26 a.m., nursing assistant (NA)-A stated R31 was dry and was offered toileting upon rising, before and after each	2 910		

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2 910	Continued From page 9	2 910		

meal and at bed time, or if the resident requests. NA-A stated R31 was independent with his urinal if left within reach, but they change his soiled incontinent product 1-2 times a day.

During further observation on 2/28/18 at 2:00 p.m., NA-B and NA-C, had just left R31's room after answering the call light, when R31 wanted to go back to bed. NA-B and NA-C both stated they checked R31's incontinent product, which was dry. Both staff members stated that R31 did not wish to use the bathroom or urinal at that time. NA-B stated the resident was routinely wet upon rising and may have to be changed throughout the day, either due to urinary incontinence or spilling the urinal on himself. NA-B and NA-C both stated R31 toileting plan was to toilet upon rising, before and after each meal and at bed time, or if resident requests. .

During interview on 3/1/17 at 10:30 a.m., the unit care manager registered nurse (RN)-A stated the facility needed to reassessed R31's toileting needs using a 3 day bladder log to determine a voiding pattern, and a time frame to assist with toileting. A reassessment of R31's toileting needs were not completed after removal of the indwelling catheter.

The facility policy, Bowel and Bladder Incontinence, revised 07/2017, indicted the following: "A resident who is incontinent of bowel and bladder receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. No Foley Catheter will be in place without documentation of clinic condition/necessary." The policy did not indicate what assessment should be done when a catheter was removed.

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2 910	Continued From page 10 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review systems to ensure catheters are appropriately documented and utilized and referrals are made as ordered. The DON could educate all responsible staff for ongoing bladder assessment and follow through. The DON could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance group for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current	21800		3/21/18

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21800	Continued From page 11 facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notices (SNFABN) for 2 of 3 residents (R25, R53) reviewed, whose Medicare A coverage ended and remained in the facility. Findings include: R25's face sheet, undated, indicated R25 was admitted 9/11/17, and was a current resident. R25's Notice of Medicare Non-Coverage (NOMNC) (CMS-10095) form, signed as received 10/16/17, indicated R25's skilled nursing services would end 10/18/17. R25's medical record was reviewed. The record lacked evidence a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) was provided to R25 to explain her financial liabilities, and opportunity to appeal the decision of non-coverage for R25, when Medicare no longer covered her stay. R53's face sheet, undated, indicated R53 was admitted on 10/26/17, and was a current resident.	21800	Corrected	

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21800	Continued From page 12 R53's Notice of Medicare Non-Coverage (CMS-10095) form, signed by the resident's representative as received 12/19/17, indicated R53's current skilled nursing services will end 12/21/17. R53's medical record was reviewed. The record lacked evidence a SNFABN was provided R25 to explain his financial liabilities and opportunity to appeal the decision of non-coverage for R53, when Medicare no longer covered his stay. When interviewed on 3/1/18 at 1:06 p.m., registered nurse (RN)-A stated residents who come to the facility, get skilled services, and then end up staying at the facility "were not getting the SNFABN" notices as they should be. RN-A stated she routinely gave residents the "NOMNC" (Notice of Medicare Non-Coverage) form, but typically they were residents who went back home after their therapy ended, and didn't require any other notice. RN-A stated she was aware that residents, whose Medicare stay ended and remained in the facility, required both a generic notice (NOMNC) and the SNFABN form. RN-A stated "We don't have a process for it." When interviewed on 3/1/18 at 1:26 p.m., the director of nursing (DON) stated she was not aware residents were not getting the required notices. The DON stated the process needed "to be tightened up more" and we would be reviewing it. The DON also stated she would bring to the administrator's attention, make the changes, and get a policy made. A policy regarding advance beneficiary notice for residents was requested, but none was provided. SUGGESTED METHOD OF CORRECTION:	21800		

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21800	Continued From page 13 The administrator or designee could develop, review, and/or revise policies and procedures to ensure staff are educated on the appropriate liability notices to provide residents at the end of Medicare services, and to ensure resident rights are communicated appropriately and acted upon. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21800		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a resident's preferences for shower frequency was honored for 1 of 1 resident (R45) who voiced concerns related to shower frequency. Findings include: R45's admission Minimum Data Set (MDS) dated 1/16/18, identified R45 had moderate cognitive impairment and required supervision while showering. The MDS identified choices in daily	21805	Corrected	3/16/18

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preferences were important to R45. The MDS indicated R45's diagnoses included cancer with metastasis (secondary cancer sites) and a seizure disorder, and also that R45 was receiving hospice services.

During observation on 2/26/18, at 2:33 p.m., R45 was well groomed, and seated in a wheelchair in her room. R45 placed her face in her hands and started crying.

When interviewed on 2/26/18 at 2:33 p.m., R45 stated she was no longer able to do all her cares for herself and really wanted to take a shower on a daily basis as she felt unclean. Further, R45 stated told staff she wanted a shower daily, but was told she could not have one everyday. R45 stated hospice gave her a shower one time a week, and the facility provided a shower one time a week as well.

R45's RCC (Rice Care Center) Resident Preferences, dated 1/11/18, identified R45 preferred a shower. The assessment did not identify how many showers a week R45 requested; however, listed a shower for Sunday and Wednesday in the morning.

The undated facility bathing schedule identified R45 was scheduled for a shower on Thursdays, provided by the hospice agency, and Sundays, provided by the facility staff.

During interview on 2/28/18, at 12:41 p.m. nursing assistant (NA)-D stated R45 received a shower twice a week, and added R45 had requested to have a shower daily. NA-D stated she was not sure why R45 was not showered daily, because the nurse manager made the bathing schedules.

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21805	Continued From page 15 During interview on 2/28/18, at 1:22 p.m., licensed practical nurse (LPN)-A stated she "was aware" R45 would like a shower daily. LPN-A stated it would be difficult to shower someone everyday, especially since there were many other residents that needed to be showered. During interview on 2/28/18, at 2:02 p.m. registered nurse (RN)-C stated R45 did tell her she wanted a shower daily, but thought R45 was scheduled for four showers a week between the facility and hospice. After reviewing the shower schedule, RN-C stated R45 was only receiving two showers a week, and she would work to increase R45's shower frequency. When interviewed on 3/1/18, at 1:50 p.m. the director of nursing stated residents should be showered "according to their preferences" and worked into the bathing schedule. The facility Patient Rights policy, dated 8/16, identified residents had the right to participate in decisions regarding their care. SUGGESTED METHOD OF CORRECTION: Social Service and/or their designee could develop /revise policies for resident choices and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, reviewed then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		

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	00313	A. BUILDING: _____ B. WING _____	03/01/2018

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21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain personal privacy for 2 of 2 residents (R12, R38) who had video monitoring devices in their rooms as an intervention to prevent falls which could be viewed by staff, visitors and other residents. Findings include: R12's diagnoses, as identified on a face sheet, undated. included anemia, and acute respiratory failure. The OBRA admission Minimum Data Set (MDS), dated 11/17/17, indicated R12 required the limited assistance of staff for bed mobility, transferring, ambulation, and most activities of daily living (ADLs). The MDS also indicated R12 had intact cognition. R12's care plan, revised 12/5/17, identified R12 was at risk for falls, related to a history or urinary urgency, and narcotic medication use. The care	21855	Corrected	3/16/18

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also indicted R12 self transferred, and had impulse control issues. A care plan intervention to prevent falls for R12 directed: "Video monitoring in place r/t (related to) frequent self transfers without asking for help."

During observation on 2/26/18 at 6:50 p.m., R12 was dressed and lying in her bed, covered with a blanket and watching a game show on TV. R12 made no effort or attempt to exit the bed. A portable, remote camera device in R12's room, located near the corner of a dresser, below the TV, was pointed toward R12 as she lay in bed.

When interviewed on 2/26/18, at 3:28 p.m. R12 stated she has fallen in her room, and "stumbled" going to the bathroom. R12 stated she has not had any injuries from her falls. R12 stated she used a walker and got reminders from staff "all the time" about using her call light to request assistance to prevent falls. R12 said nothing about the video monitor in her room as an aid to prevent falls.

R38's diagnoses, as identified on a face sheet, undated, included Parkinson's disease, syncope (fainting) and dementia. The quarterly MDS, dated 1/9/18, indicated R38 required extensive assistance from staff for bed mobility, transferring, ambulation, locomotion and most ADLs, including toileting. The MDS also indicated R38 was cognitively impaired.

R38's care plan, dated 2/20/18, identified R38 was at risk for falls, had unstable balance, was impulsive in her actions, and required assistance of staff for all mobility. R38's care plan directed use of a video monitor: "Will be on resident when she is lying in bed so staff can see her in team

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room when she starts to move to get out of bed, and get to her quicker to reduce her fall risk."

During observation on 2/26/18 at 6:54 p.m., R38 was lying in her bed, asleep; the light above R38's bed was on. A portable, remote camera was on a counter, under the TV in R38's room, and the lens was pointing toward R38.

When interviewed on 2/26/18 at 6:55 p.m., nursing assistant (NA)-F stated both R38 and R12 had cameras in their rooms, which should be running, and they could be watched in the "Team room." NA-F stated the room where staff checked email and where resident charts were stored was called the "Team" room.

The nursing/chart or "Team" room was observed on 2/26/18, 6:57 p.m. in the Cushman Cottage unit was approximately 8' (feet) by 10' in size, and located across and east of the resident dining room. The room had windows on the north and west sides. The west window opened into the dining room and hallway, where other residents, visitors and staff could easily view inside the Team room. Inside the Team room were two, color video monitors, one for R38 and one for R12, which broadcasted the live activity of each resident from cameras in their rooms. The monitor screens were approximately 2" (inches) by 4", and R38's and R12's live video from their rooms could seen by anyone walking past and looking through the west window. The video monitor screens could also be seen through the Team room's south entry, which had no door. The Team room was in a common area where residents, visitors, and staff frequented throughout the day.

Continuing observation on 2/26/18, between 6:57

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p.m. and 7:33 p.m., the video feeds, capturing R38's and R12's movements while they lay in bed, ran continuously. During this time, nursing staff were present in the area, intermittently walking past the Team room while completing evening routines. At 7:15 p.m., from inside the Team room, the surveyor observed R12 on the video monitor. R12 was laying in bed and taking a drink from a mug through a straw; a visitor was present in the room. At the same time, and on a different monitor, R38 also was also seen, in bed, asleep. At 7:20 p.m., a unidentified nursing assistant briefly entered the Team room, briefly glanced at the monitors, then pulled something from a cupboard and exited. When the surveyor exited the area at 7:33 p.m., the video feed from both R38's and R12's rooms continued, which could be seen by other residents, visitors whom walked past the west window of the Team room.

During intermittent observations on 2/27/18 between 8:17 a.m. and 10:45 a.m., there was live, continuous video feed from R38's and R12's rooms, which broadcast on the monitors in the Team room on the Cushman Cottage unit. R38 and R12 were visible in the monitors. During the observations, both R38 and R12 were and remained asleep in their rooms, in bed, and covered with blankets. Also, nursing assistants, a housekeeper, a visitor, homemaker staff, nurses, physical therapy staff, and hospice employees, all walked past the Team room, and its west window, allowing a glance into the room. Staff freely entered the room, sat at the counter in front of the video monitors, completed their work, then left. At times the Team room was unattended, but live video feed from R38's and R12's rooms ran continuously, and could be seen by anyone who looked into the Team room from the west window.

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When interviewed on 2/28/17 at 1:25 p.m., nursing assistant (NA)-E stated the purpose of the video was because R12 and R38 were fall risks, and we want to allow them to be as independent as possible. NA-E stated when cares were performed, the cameras were to be covered, or turned away from the residents. NA-E stated the camera feed was visible from the 'Team' rooms, and that usually only nursing staff were in the room, but stated residents often go near and by the room.

When interviewed on 2/28/17 at 2:37 p.m., NA-G stated the video monitors were left on all the time, and during cares, the camera was to be turned "so nobody can see" during cares, because the feed was in the (Team) room. NA-G thought it "was possible" for people both in and out of the room to see the room monitors, because there was "a lot of traffic" going past outside the room, and you could see the screens through the window, from outside the Team room in the hallway. NA-G said the Team room was for staff, but stated she has seen families step into the room "to ask us a question."

When interviewed on 3/1/18 at 9:59 a.m., registered nurse (RN)-B stated over the years she considered use of video monitoring of residents for various reasons, but stated thought the practice to be "invasion of privacy" for residents. RN-B stated the use of a monitor did not replace staff. Additionally, RN-B stated if no one monitored the video, because staff were busy, it served little purpose. RN-B stated it was more a matter of luck if you saw and caught a resident trying to stand up or get out of bed on his own. RN-B also stated she would not want to see personal cares on a monitor in the Team room because "it's not just nursing staff" that use the

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team rooms. RN-B stated if the IT (information technology) person were in the room and watched cares this would be a "a privacy issue" for residents.

When interviewed on 3/1/18 at 11:15 a.m., registered nurse (RN)-C stated R12 and R38 each had video monitoring, and their use was as fall intervention strategies. RN-C stated the video monitor was "an extra tool" for staff to increase observation, and the practice had been in place for some time. RN-C stated when she worked the floor, she had successfully intervened to help residents because video monitoring was present. RN-C added when staff were busy, unavailable, or if no one was watching the video, the tool was ineffective. RN-C did not know of specific guidelines as to when the video monitors were to be on or turned off, but stated when staff were in the room providing cares, the cameras were turned away from the resident or covered. RN-C stated that since she has been in her role as a coordinator, she has "questioned" the use of the video "as far as it related to privacy" for residents. RN-C stated it has "crossed her mind" that just because something was used and had been in place, and was practiced, "I should not have assumed" that is was ok.

When interviewed on 3/1/18 at 1:30 p.m., the director of nursing (DON) stated the purpose of most of the monitors was as a fall intervention, and stated before their use, we get "Okays" from families prior to their use. The DON stated the use of video monitoring "has been in place" for some time, but added, "that is not really an excuse" if it is a privacy issue. The DON was not aware a of a specific policy or guidelines for the use of video monitors.

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21855	Continued From page 22 A facility policy, Patient Rights, revised 8/2016, indicated the facility "will establish mechanisms and processes to support" resident rights. The policy identified "Right to personal privacy and confidentiality" and indicated "Patients/residents have the right to respectfulness and privacy as it relates to their medical and personal care." SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) could review and revise policies and procedures as related to resident privacy, and educate staff on the policies. The DON or designee could complete random audits to ensure policy and procedures are followed and resident privacy is maintained. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21855		