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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XYHQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00041

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245490**

2. STATE VENDOR OR MEDICAID NO. (L2) **915525200**

3. NAME AND ADDRESS OF FACILITY
(L3) **OAK HILLS LIVING CENTER**
(L4) **1314 EIGHTH STREET NORTH**
(L5) **NEW ULM, MN** (L6) **56073**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/27/2016** (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 **94** (L18)

13.Total Certified Beds **94** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	94			
(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 :
Gary Nederhoff, Unit Supervisor 01/04/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/10/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **08/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245490

January 10, 2017

Ms. Candas Schouvieller, Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, MN 56073

Dear Ms. Schouvieller:

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 December 21, 2016 the above facility is certified for:

94 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 94 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
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 4, 2017

Ms. Candas Schouvieller, Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, MN 56073

RE: Project Number S5490027

Dear Ms. Schouvieller:

On November 15, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 3, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On December 27, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 2, 2016 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 November 3, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 21, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 3, 2016, effective December 21, 2016 and therefore remedies outlined in our letter to you dated November 15, 2016, 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
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245490 Y1	A. Building B. Wing Y2	12/27/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	1314 EIGHTH STREET NORTH NEW ULM, MN 56073

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282	Correction	ID Prefix F0311	Correction	ID Prefix F0314	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(a)(2)	Completed	Reg. # 483.25(c)	Completed
LSC	11/21/2016	LSC	11/21/2016	LSC	11/21/2016
ID Prefix F0327	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(j)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/21/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 1/4/2017	SIGNATURE OF SURVEYOR 10160	DATE 12/27/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
11/3/2016	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245490	A. Building 01 - MAIN BUILDING 01 B. Wing	12/2/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	1314 EIGHTH STREET NORTH NEW ULM, MN 56073

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 11/02/2016	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 11/02/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 1/4/2017	SIGNATURE OF SURVEYOR 37008	DATE 12/2/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
11/2/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XYHQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00041

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245490**

2. STATE VENDOR OR MEDICAID NO. (L2) **915525200**

3. NAME AND ADDRESS OF FACILITY
(L3) **OAK HILLS LIVING CENTER**
(L4) **1314 EIGHTH STREET NORTH**
(L5) **NEW ULM, MN** (L6) **56073**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **11/03/2016** (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 **94** (L18)

13.Total Certified Beds **94** (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
	94			
(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 :
Wendy Buckholz, HFE NE II 11/23/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/07/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
08/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 15, 2016

Ms. Candas Schouvieller, Administrator
Oak Hills Living Center
1314 Eighth Street North
New Ulm, MN 56073

RE: Project Number S5490027

Dear Ms. Schouvieller:

On November 3, 2016, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

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 December 13, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 3, 2017 (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 May 3, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245490	A. BUILDING _____ B. WING _____	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	1314 EIGHTH STREET NORTH NEW ULM, MN 56073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide pressure ulcer care as directed by the care plan for 1 of 3 residents (R16) observed during a dressing change of a pressure ulcer and failed to implement an ambulation program as directed by the plan of care for 1 of 1 resident (R52) reviewed for activities of daily living. Findings include: R16 had re-entry date on 7/16/16, with diagnoses including: dysphasia (difficulty swallowing), muscle wasting and atrophy and chronic venous insufficiency per the physician order summary	F 282	F282 CORRECTIVE ACTION: Regarding R16, nurse (LPN-A) was educated immediately. Nurse was instructed to change dressing to appropriate dressing as ordered. Nurse (LPN-A) was required to complete the facility QA Treatment Error Follow Report. Education was provided at daily huddles. Director of Nursing to provide facility wide nurse education on the importance of following treatment as ordered by care provider. We will continue to discuss	11/21/16

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

Electronically Signed | 11/16/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245490	A. BUILDING _____ B. WING _____	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	1314 EIGHTH STREET NORTH NEW ULM, MN 56073

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F 282	Continued From page 1 record. R16's most recent annual Minimum Data Set (MDS) assessment dated 9/14/16, indicated R16 required extensive assistance of two staff with bed mobility, transferring and toilet use. The Brief Interview for Mental Status (BIMS) noted R16 had a score of 12 indicating cognitively intact. The assessment further identified R16 had an unhealed stage 2 pressure ulcer (PU) measuring 3 centimeters (cm) length (L) by 3 cm width (W). Review of the most recent care plan included: Treatment to pressure ulcer on right buttock-per medical Doctor (MD)/ Nurse practitioner (NP) orders. Refer to NP wound specialist as needed (date care plan intervention initiated: 9/20/16). Review of the faxed physician order dated 10/11/16, included: change treatment: wound cleanser, pat dry, apply calcium alginate to wound bed, cover with foam change every other day. Attached to the fax was a nursing progress note dated 10/9/16, indicating the right buttock ulcer measuring 2.5 cm (L) by 1.5 cm (W) 0 cm depth (D) and was oval shaped. The electronic treatment record (TAR) reflected the change in order dated 10/11/16, at 11:06 a.m. During observation on 11/2/16, at 3:49 p.m. licensed practical nurse (LPN)-A removed the soiled dressing located on the right buttock, which was noted to have moderate to large amount of yellow/green exudates on dressing. Following appropriate hand hygiene, LPN-A cleansed the right buttock PU with wound cleanser and patted the wound bed dry, which was yellow in color. A foam dressing was subsequently applied over the ulcer. LPN-A failed to apply calcium alginate to the wound bed prior to applying the foam dressing as directed by the physician order on 10/11/16.	F 282	wounds once a week during our IDT meetings and conduct monthly audits. Regarding R52 - We have educated staff during daily huddles and educated NA-A the importance of following the care plan. Household Coordinator will conduct weekly audits x one month to ensure resident□s walking program is being carried out. Staff Development Director will conduct monthly audits on ambulation programs. ACTUAL/PROPOSED COMPLETION DATE: 11/21/2016 PERSON RESPONSIBLE FOR CORRECTION/MONITORING: Case Manager, Household Coordinator, Staff Development, Director of Nursing and Administrator.	

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F 282	Continued From page 2 When interviewed on 11/2/16, at 4:20 p.m. the director of nursing (DON) reviewed the wound care orders and examined the wound care kit for R16 and verified there was no calcium alginate packages present but was able to locate them in the storage cabinet in the medication room. LPN-A was also present during the interview and verified the calcium alginate was not placed in the wound bed as she was unaware the order changed on 10/11/16. The DON directed LPN-A to redress the PU as soon as possible. Review of the TAR and nurse progress notes indicated the buttock treatment had been performed incorrectly 5 of 11 dressing changes by LPN-A for the month of October and once in November 2016. During an interview on 11/3/16, at 8:00 a.m. the DON reported that her investigation revealed there was only one staff member not completing the dressing change to the right buttock as ordered by the MD/NP and indicated LPN-A was re-educated. R52 physician progress note dated 10/17/16, listed current diagnoses: congestive heart failure (CHF), rheumatoid arthritis, essential hypertension and macular degeneration. Document review of R52's care plan dated 10/31/16, included a problem of altered self-care performance, limited physical mobility related to weakness and arthritis. Interventions included: Walk daily to all meals and one additional walk throughout the day; requires extensive assist of 1 to transfer and ambulate.. The document titled Coordination of Care dated 7/29/16, identified that R52 is having increasing difficulty according to therapy. Treatment update included- Walk to/from meals and on weekend an additional longer walk. When interviewed on 11/1/16, at 4:45 p.m. family	F 282		

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F 282	Continued From page 3	F 282		

member (F)-B expressed concern that R52 was not walked according to the plan established for ambulation to/from the meal. FM-B indicated that R52 continues to report that she is not walked to every meal.

During observation on 11/1/16, at 6:12 p.m. R52 wheeled herself in the wheelchair from the dining room to her room. During interview with R52 on 11/1/16, at 6:15 p.m. it was confirmed that she had not been walked to/from the evening meal.

It was observed on 11/2/16, at 9:26 a.m. that a volunteer transported R52 to the dining room and at 9:42 a.m. R52 informed the surveyor she was suppose to walk to the meal but it did not happen.

It was noted on 11/2/16, at 9:50 a.m. that R52 was returned to her room via her wheelchair by staff. After R52 had attended the morning exercise activity at 11:00 a.m., she again was returned to her room at 12:10 p.m. and then transported to the noon meal in her wheelchair. After the noon meal was finished, R52 wheeled herself back to her room via the wheelchair at 1:18 p.m.

When interviewed on 11/2/16, at 1:32 p.m. R52 reiterated she had not been assisted with ambulation yet today.

During interview with nursing assistant (NA)-A on 11/2/16, at 2:04 p.m. it was verified that R52 had not yet been walked. NA-A was the staff assigned to provide cares for R52.

When interviewed on 11/2/16, at 3:31 p.m. nurse manager (NM)-A verified the care plan indicated that R52 was to be walked to meals three times per day and staff were expected to follow the plan of care.

A policy related to walking programs/plan of care was requested but not provided.

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F 282	Continued From page 4	F 282		
F 311 SS=D	. 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide ambulation assistance for 1 of 1 resident (R52) reviewed for ambulation with activities of daily living (ADL's). Findings include: R52's physician progress note dated 10/17/16, listed current diagnoses: congestive heart failure (CHF), rheumatoid arthritis, essential hypertension and macular degeneration. R52 was assessed to have mild cognitive impairment according to the most recent Minimum Data Set (MDS) assessment dated 10/12/16. Further MDS assessment review identified that R52 had no mood or behaviors issues, no symptoms of delirium, is usually understood and understands others. The MDS identified R52 required extensive assistance by one staff with ambulation off the unit. Document review of R52's care plan dated 10/31/16, included a problem of altered self-care performance, limited physical mobility related to weakness and arthritis. The intervention identified	F 311	F311 CORRECTIVE ACTION: Regarding R52 - We have educated staff during daily huddles and educated NA-A the importance of following the care plan. Household Coordinator will conduct weekly audits x one month to ensure resident□s walking program is being carried out. Staff Development Director will conduct monthly audits on ambulation programs. ACTUAL/PROPOSED COMPLETION DATE: 11/21/2016 PERSON RESPONSIBLE FOR CORRECTION/MONITORING: Case Manager, Household Coordinator, Staff Development, Director of Nursing and Administrator.	11/21/16

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F 311	Continued From page 5	F 311		

included: (1) Walk daily to all meals and (2) one additional walk throughout the day; requires extensive assist of 1 to transfer and ambulate.
The document titled Coordination of Care dated 3/4/16, identified a treatment update from physical therapy related to walking: Staff will walk with the resident to meals and one additional time mid-morning or mid-afternoon per resident availability. The Coordination of Care dated 7/29/16, identified that R52 is having increasing difficulty according to therapy. Treatment update included: Walk to/from meals and on weekend an additional longer walk.
When interviewed on 11/1/16, at 4:45 p.m. family member (F)-B expressed concern that R52 was not walked according to the plan established for ambulation to/from meals. F-B expressed frustration because the family had addressed this with nurse manager (NM)-A, who informed FM-B the problem would be addressed. F-B indicated that R52 continues to report that she is not walked to every meal.
During observation on 11/1/16, at 6:12 p.m. R52 wheeled herself in the wheelchair from the dining room to her room. During interview with R52 on 11/1/16, at 6:15 p.m. it was confirmed that she had not been walked to/from the evening meal.
It was observed on 11/2/16, at 9:26 a.m. that a volunteer transported R52 to the dining room and at 9:42 a.m. R52 informed the surveyor she was suppose to walk to the meal but it did not happen.
It was noted on 11/2/16, at 9:50 a.m. that R52 was returned to her room via her wheelchair by staff. After R52 had attended the morning exercise activity at 11:00 a.m., she again was returned to her room at 12:10 p.m. and then transported to the noon meal in her wheelchair.
After the noon meal was finished, R52 wheeled herself back to her room via the wheelchair at

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F 311	Continued From page 6 1:18 p.m. R52 was not walked to the breakfast nor the noon meal, When interviewed on 11/2/16, at 1:32 p.m. R52 reiterated she had not been assisted with ambulation yet today. During interview with nursing assistant (NA)-A on 11/2/16, at 2:04 p.m. it was verified that R52 had not yet been walked. NA-A was the staff assigned to provide cares for R52. When interviewed on 11/2/16, at 3:31 p.m. NM-A verified the care plan indicated that R52 was to be walked to meals three times per day and staff were expected to follow the plan of care. A policy related to walking programs/plan of care was requested but not provided.	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed implement a physician prescribed order related to the treatment of a pressure ulcer for 1 of 3 (R16) residents reviewed with pressure ulcers. Findings include: R16 was re-admitted on 7/16/16, with diagnoses	F 314	F314 CORRECTIVE ACTION: Regarding R16, nurse (LPN-A) was educated immediately. Nurse was instructed to change dressing to appropriate dressing as ordered. Nurse (LPN-A) was required to complete	11/21/16

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F 314	Continued From page 7 including: dysphasia (difficulty swallowing), muscle wasting and atrophy and chronic venous insufficiency per the physician order summary record. R16's most recent annual Minimum Data Set (MDS) assessment dated 9/14/16, indicated R16 required extensive assistance of two staff with bed mobility, transferring and toilet use. The Brief Interview for Mental Status (BIMS) identified R16 of having a score of 12 indicating to be cognitively intact. The assessment further identified R16 as having a unhealed stage II pressure ulcer (PU) measuring 3.0 centimeters (cm) length (L) by 3.0 cm width (W). Review of the most recent care plan included: Treatment to pressure ulcer on right buttock-per medical doctor (MD)/ nurse practitioner (NP) orders. Refer to NP wound specialist as needed (date care plan intervention initiated: 9/20/16). Review of a faxed physician order dated 10/11/16, included: change treatment: wound cleanser, pat dry, apply calcium alginate to wound bed, cover with foam and change every other day (QOD). Attached to the fax was a nursing progress note dated 10/9/16, indicating R16's right buttock ulcer measured 2.5 cm (L) by 1.5 cm (W) by 0 cm depth (D) and was oval shaped. Review of the electronic treatment record (TAR) revealed the following wound treatment order: Order dated: 10/11/16, at 11:06 a.m.-Treatment to right buttocks: wound cleanser, pat dry, apply calcium alginate to wound bed cover with foam, change QOD in the evening. It was noted that the previous wound care order had not included the application of calcium alginate to the wound bed. During observation on 11/2/16, at 3:49 p.m. licensed practical nurse (LPN)-A removed R16's soiled dressing located on the right buttock, which	F 314	the facility QA Treatment Error Follow Report. Education was provided at daily huddles. Director of Nursing to provide facility wide nurse education on the importance of following treatment as ordered by care provider. We will continue to discuss wounds once a week during our IDT meeting and conduct monthly audits. ACTUAL/PROPOSED COMPLETION DATE: 11/21/2016 PERSON RESPONSIBLE FOR CORRECTION/MONITORING: Case Manager, Household Coordinator, Staff Development, Director of Nursing and Administrator.	

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F 314	Continued From page 8	F 314		

was noted to have moderate to large amount of yellow/green exudate on the dressing. Following appropriate hand hygiene, LPN-A cleansed the right buttock PU with wound cleanser and patted the wound bed dry, which was yellow in color. LPN-A then applied a foam dressing over the ulcer. LPN-A failed to apply calcium alginate to the wound bed prior to applying the foam dressing as directed by the physician order dated 10/11/16.

During observation on 11/3/16, at 12:57 p.m. the nurse practitioner (NP) wound specialist changed the right buttock dressing per MD/NP orders. Greenish drainage was noted on the soiled dressing when removed. The measurements for the wound were documented as: 1.0 cm (L) by 2.4 cm (W). The NP was unable to determine an accurate depth. The NP indicated there were changes noted to the wound bed but could not determine whether it was related to the inconsistent application of calcium alginate to the wound bed or related to the declining condition and malnutrition R16's was experiencing.

When interviewed on 11/2/16, at 4:20 p.m. the director of nursing (DON) reviewed R16's wound care orders and examined the wound care kit for R16. The DON verified there were no calcium alginate packages present but was able to locate some in the storage cabinet located in the medication room. LPN-A, who was also present during the interview, verified the calcium alginate was not placed in the wound bed as she was unaware the order changed as of 10/11/16. The DON directed LPN-A to redress the PU as soon as possible with the appropriate treatment. Review of the TAR and nurse progress notes indicated the buttock treatment had been

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F 314	Continued From page 9 performed 5 of 11 dressing changes by LPN-A for the month of October and once in November 2016. During a subsequent interview on 11/3/16, at 8:00 a.m. the DON reported an investigation of R16's PU treatment had been conducted and revealed there had been 1 licensed staff (LPN-A) who had not been following the current physicians orders, which included the application of calcium alginate. Review of the facility's Pressure Ulcer Prevention Policy and Procedure dated 4/13, did not direct staff to follow MD/NP orders.	F 314		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 1 resident (R42) reviewed for hydration was provided encouragement to drink sufficient fluids to maintain hydration status. Findings include: R42's annual Minimum Data Set (MDS) assessment dated 8/31/16, indicated a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact). The MDS identified diagnoses of altered mental status, renal	F 327	F327 CORRECTIVE ACTION: Education was provided to staff at daily huddles to encourage intakes and assist resident as needed with meals. Dietician added documentation encourage fluids at meals on dietary card in the dining room to prompt staff at time of meal service. Resident is currently care planned to be offered fluids 6 times daily in addition to meals. Staff has been educated to re-approach resident when she has	12/21/16

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F 327	Continued From page 10 insufficiency and malnutrition. The MDS further identified R42 was independent with eating and required setup help only. A dehydration evaluation dated 8/31/16, identified a score of 4, with risk factors of mild to moderate impairment in mental status which put her at mild risk for dehydration. R14's nutritional assessment dated 6/6/16, indicated R42's daily fluid needs were 1500 milliliters (ml) per day. R42's Care Area Assessment (CAA) related to dehydration and fluid maintenance dated 9/2/16, indicated R42 had been hospitalized on 8/27/16 with acute delirium and dehydration secondary to a general health decline. The CAA further indicated R42's risk for dehydration would increase as her health continued to decline, identified that R42 had a diagnosis of cancer and indicated staff were to encourage her to eat and drink t/o (throughout) the day. R42's 14-day medicare MDS dated 10/20/16, indicated R42 had been dehydrated during the look back period and identified a BIMS score of 9 (moderate cognitive impairment), significantly decreased from the 8/31/16 assessment. R42's care plan dated 11/3/16, identified R42 had chronic obstructive pulmonary disease (COPD) secondary to lung cancer with secondary metastasis to the brain, was independent with eating after setup, was to be offered 120 cubic centimeters (cc's) of fluid between meals consisting of Boost breeze, juice or water and was to be observed to changes in ability to hydrate/feed herself.	F 327	refused at any given time and as tolerated. A variety of fluids are offered daily. Dietician will audit fluid intake weekly x one month. We monitor hydration on all residents during the quarterly assessment with significant changes and as needed. Dietician will be conducting an in-service on hydration at the nurse/TMA and RNA meetings on December 21, 2016. Dietician will complete monthly audits on other residents who have a diagnosis of dehydration or at high risk of dehydration. The monthly dehydration audits will be discussed at the quarterly QA Meetings. ACTUAL/PROPOSED COMPLETION DATE: 12/21/2016 PERSON RESPONSIBLE FOR CORRECTION/MONITORING: Dietician, Household Coordinator, Case Manager, Director of Nursing and Administrator.	

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F 327	Continued From page 11	F 327		

R42's quality of life progress note dated 10/27/16, identified R42 was severely impaired with decision making and had not been feeling well, and was not paying full attention to the date, time, etc. The note also indicated R42's cognitive status fluctuated.

R42's basic metabolic panel lab results (a lab panel to assess indicators of electrolyte, kidney functioning and fluid balance) with medical provider comments dated 10/05/16, indicated R42's kidney function had declined since the previous visit, likely due to dehydration. The report also indicated staff should inform R42's family that it was very important R42 drink enough water, at least 8 ounces of water daily, not coffee, which was dehydrating. The next follow up appointment was listed as 11/2/16.

R42's 11/2/16 laboratory results included complete blood counts, but no basic metabolic panel. A handwritten note by the clinic staff indicated R42 was confused and inquired if another sodium level should be checked, which was to be reviewed with R42's primary physician.

R42's point of care response history including the dates of 10/31/16 - 11/2/16 indicated R42 had received supervision once with eating and had refused on one other occasion.

R42's fluid intake documentation for the previous 31 days of October 2015 indicated an average daily fluid intake of 588 cc's per day, significantly less than the 1500 cc's the nutritional assessment indicated were required.

During observation on 10/31/16, at 5:05 p.m. R42

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	245490	A. BUILDING _____ B. WING _____	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK HILLS LIVING CENTER	**1314 EIGHTH STREET NORTH NEW ULM, MN 56073**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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was noted in the dining area wheeling herself to and from the table. R42 had a covered coffee mug in a drink holder attached to her chair, which she indicated contained coffee. During interview at this time, R42 was confused as to place and time. No cracking or dryness of the mucous membranes was observed. At 5:07 p.m. an unidentified nursing assistant (NA) asked what beverage R42 would like to drink and placed them in front of R42. The beverages included a mug of coffee and a glass of cranberry juice. R42 continued to frequently wheel self away from the table and was redirected back to the table by staff, seldom taking a drink from her beverages. No encouragement to finish her fluids was observed to be provided. At 5:25 p.m. R42 was noted to be wheeling away from the table and had not consumed any of her coffee or juice, was distracted, looking around the room and was folding and re-folding her napkins. At 5:43 p.m. R42 was noted to wheel herself away from the dinner table after consuming a few bits of her meat and drinking less than half of her juice and/or coffee.

During observation on 11/02/16, at 8:23 a.m. R42 was noted to be asleep in bed, with a jug of water next to her on a bedside table. The water pitcher was cool to the touch.

During observation on 11/02/16, at 9:17 a.m. R42 was seated at the dining room table eating breakfast. Family member (F)-D was noted to be seated next to her. R42 had consumed only approximately 60 cc's of the fluids in front of her consisting of coffee, juice and a full glass of ice water. No encouragement to finish fluids was provided by nursing staff in the dining area. Nursing staff were noted to be in the dining area;

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however, had not encouraged R42 to finish her fluids.

During interview on 11/2/16, at 9:34 a.m. NA-C indicated R42 received cups of water in her room, drank coffee but refused water. NA-C also indicated R42 would sometimes drink cranberry juice.

During interview on 11/2/16, at 9:36 a.m. NA-D indicated R42 "has not had anything [fluids] since I got here this morning, daughter has been in there, we would have to ask her. She just went out to breakfast." NA-D indicated staff were to offer fluids to her with each contact and that R42 "may need some cueing" to drink her fluids but fed herself food independently.

During observation on 11/02/16, at 12:32 p.m. R42 was seated in the dining room with F-D. R42 was noted to be folding and re-folding her clothing protector repeatedly. A small carton of a nutritional supplement was in front of her, with less than one half of the supplement gone. Three nursing staff were in the dining area, but did not encourage R42 to finish her fluids. FM-D wheeled R42 away from the table asking her if she was done, poured coffee into a covered mug located on her wheelchair and transported R42 back to her room without any encouragement to finish her fluids.

During interview on 11/1/16, at 5:29 p.m. NA-B indicated R42 usually drinks "pretty good" at meals and did ask to have her coffee mug filled.

During interview on 11/2/16, at 12:45 p.m. F-D indicated she was not aware of R42's lab results from her 10/6/16 appointment. She had

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accompanied R42 to the medical appointment but the lab results were not available at the time they left. In addition, staff had not instructed her that she should be encouraging fluid intake other than coffee for R42 consumption. F-D further stated she had accompanied R42 to the follow-up doctor appointment today [11/2/16]; however, she was not sure which blood work had been done. F-D verified R42 had been more confused recently.

During interview on 11/02/16, at 2:20 p.m. the dietician/food service director (FSD) indicated R42's intakes were monitored at each meal and fluids should be encouraged at each contact and in between meals. The FSD indicated fluid intakes were monitored on a quarterly basis and with significant changes in weight. The FSD further indicated R42 did need some help with eating and was confused; however, was not sure how much help R42 would accept.

During interview on 11/03/16, at 10:17 a.m. the director of nursing (DON) indicated she would expect staff to encourage fluids for R42 at meals and respect R42's right to refuse. The DON indicated R42 had been making most of her own health care decisions and should be interviewable about her hydration status. The DON further stated R42's physician had recommended hospice, however family was not ready to pursue this.

During a follow up observation and interview on 11/03/16, at 10:50 a.m. R42 stated "maybe not," when asked if she was receiving enough help with drinking fluids at meals. R42 indicated she was thirsty at this time. When asked if she could manage the ice water pitcher at bedside she indicated, "it's not as easy as it seems." NA-C

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F 327	Continued From page 15 was informed R42 was thirsty at this time and came to the room to assist R42. R42 did take drinks from the mug when offered by NA-C at this time. R42 was not able to recall her physician's appointment yesterday and was slow to respond when answering questions. The facility policy, entitled Hydration, undated indicated individuals at risk for dehydration will be identified, assessed and provided with sufficient fluid intake to maintain proper hydration and health.	F 327		

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K 000	INITIAL COMMENTS FIRE SAFETY Aspen with Deficiencies THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 11/2/16, (Oak Hills Living Center) was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/18/2016

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	K 000		

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.

The nursing home is separated from an assisted living facility by 2-hour fire walls, with opening protectives consisting of labeled, self-closing, positive latching, 90-minute fire door assemblies.

BUILDING:
This 2-story with no basement facility was constructed in 1995, is fully sprinklered, and was determined to be of Type II (111) construction.

An addition was constructed in 2009, is two-stories, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction.

The facility has a capacity of 95 beds and had a census of 93 at the time of the survey.

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by:	K 363		11/2/16

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K 363	Continued From page 3 Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. On facility tour between 09:00 AM and 12:30 PM on 11/2/2016, based on observation and interview revealed that the findings include: During inspection of facility it was observed that	K 363	K-Tag363 Corrective Action: Maintenance Director adjusted the door closers. Maintenance department will complete Monthly checks during monthly fire drills. Actual/proposed Completion Date: 11/2/2016 Person Responsible for Correction/Monitoring: Maintenance Director and Administrator.	

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K 363	Continued From page 4 the fire doors in 1st and 2nd floor family rooms did not close when tested. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 363		
K 372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.	K 372	K-Tag 372 Corrective Action: Maintenance Director adjusted the door closers. Maintenance department will complete Monthly checks during monthly fire drills. Actual/proposed Completion Date: 11/2/2016 Person Responsible for	11/2/16

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K 372	Continued From page 5 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. On facility tour between 09:00 AM and 12:30 PM on 11/2/2016, based on observation and interview revealed that the findings include: During inspection of facility it was observed that the 1st floor smoke barrier doors located by room 116 did not close when tested. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of	K 372	Correction/Monitoring: Maintenance Director and Administrator.	