DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: YFI9 Facility ID: 00557

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MEDICARE/MEDICAID PROVIDIO (L1) 245554 2.STATE VENDOR OR MEDICAID N (L2) 792697900		3. NAME AND AI (L3) RENVILLA (L4) 205 SOUTH	HEALTH CE EAST ELM A	NTER	(L6) 56284	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW			
5. EFFECTIVE DATE CHANGE OF (L9) 07/01/2005	5/2014 (L34) (L10)	(L5) RENVILLE 7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct	<u></u>	GORY 09 ESRD 10 NF 11 ICF/IIE	02 (L7) 13 PTIP 22 CLIA 14 CORF	5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35)			
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30			
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	' IS CERTIFIED	AS:					
From (a): To (b):			nce With equirements e Based On:		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN	The Following Requirements: 6. Scope of Services Limit 7. Medical Director			
12.Total Facility Beds	56 (L18)	•	cceptable POC						
13.Total Certified Beds	56 (L17)		npliance with Progents and/or Appli			(L12)			
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS				
18 SNF 18/19 SNF 56	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)			
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION 1	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:			
Gloria Derfus, Supervisor		1	0/07/2014	(L19)	Anne Kleppe, Enforcement Specialist 10/07/2014(L20)				
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY			
19. DETERMINATION OF ELIGIBIDE _X 1. Facility is Eligible to F 2. Facility is not Eligible	Participate		IPLIANCE WITE HTS ACT:	H CIVIL	 21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : 				
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT .	26. TERMINATION ACTION	: (L30)			
OF PARTICIPATION 04/01/1991	BEGINNING		ENDING DA		VOLUNTARY 00 01-Merger, Closure	. ,			
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	** - *** - *** - *********************			
25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER			
	B. Resema Se	ispension Bute.	(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS				
		03001							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539		DETERMINATION 09/16/2014	OF APPROVAL	-					
	(L32)			(L33)	DETERMINATION APP	ROVAL			



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5554

Electronically Delivered: September 18, 2014

Ms. Cami Peterson-Devries, Administrator Renvilla Health Center 205 Southeast Elm Avenue Renville, Minnesota 56284

Dear Ms. Peterson-Devries:

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 September 8, 2014, the above facility is certified for:

56 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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,

Dire Klegge

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program

Division of Compliance Monitoring

Minnesota Department of Health Email: anne.kleppe@state.mn.us

Telephone: (651) 201-4124 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: September 18, 2014

Ms. Cami Peterson-Devries, Administrator Renvilla Health Center 205 Southeast Elm Avenue Renville, Minnesota 56284

RE: Project Number S5554025

Dear Ms. Peterson-Devries:

On August 14, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 25, 2014. 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 September 15, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 18, 2014 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 July 25, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 8, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 25, 2014, effective September 8, 2014 and therefore remedies outlined in our letter to you dated August 14, 2014, 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,

Dire Klegge

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program

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Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245554	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/15/2014
Nam	e of Facility		Street Address, City, State, Zip Code	
RE	ENVILLA HEALTH CENTER		205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix Reg. # LSC	F0167 483.10(g)(1)		Correction Completed 09/08/2014	ID Prefix Reg. # LSC	F0225 483.13(c)(1)(ii)-(i		Correction Completed 09/08/2014			F0226 483.13(c)		Correction Completed 09/08/2014
ID Prefix Reg. # LSC	F0250 483.15(g)(1)		Correction Completed 09/08/2014	ID Prefix Reg. # LSC	F0272 483.20(b)(1)		Correction Completed 09/08/2014		ID Prefix Reg. # LSC	F0309 483.25		Correction Completed 09/08/2014
ID Prefix Reg. # LSC	F0323 483.25(h)		Correction Completed 08/20/2014	ID Prefix Reg. # LSC	F0353 483.30(a)		Correction Completed 09/02/2014			F0371 483.35(i)		Correction Completed 08/28/2014
ID Prefix Reg. # LSC			Correction Completed	Reg. #			Correction Completed					
ID Prefix Reg. # LSC				ID Prefix Reg. # LSC			Correction Completed					
Reviewed E	By R	eviewed	Ву	Date:	Signature	of Sur	vevor:				Date:	
State Agen		GD/AK	-	10/07/20	_	0. 0	,		18	3623		15/2014
	•	eviewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
Followup t	o Survey Comp 7/25/2		:		Check for any Uncorrecte					Summary o the Facility		NO

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number 245554	(Y2) Multiple Construction A. Building B. Wing 01 - MA	IN BUILDING 01	(Y3) Date of Revisit 9/18/2014
Name of Facility		Street Address, City, State, Zip Code	
RENVILLA HEALTH CENTER		205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	=

(Y4) Item	(Y	5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	()	(5) I	Date
		Correction Completed			Correction Completed					Correction Completed
ID Prefix		07/25/2014	ID Prefix				ID Prefix			-
•	NFPA 101	<u> </u>	Reg. #				Reg. #			_
LSC	K0072	_	LSC				LSC			=
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix			ID Prefix				ID Prefix			=
Reg. #		<u> </u>	Reg. #				Reg. #			_
LSC		_	LSC				LSC			-
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix			ID Prefix				ID Prefix			<u> </u>
Reg. #		<u> </u>	Reg. #				Reg. #			_
LSC		_	LSC				LSC			=
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix			ID Prefix				ID Prefix			=
Reg. #		<u> </u>	Reg. #				Reg. #			_
LSC			LSC				LSC			=
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		<u> </u>	ID Prefix	-			ID Prefix			_
Reg. #		<u> </u>	Reg. #				Reg. #			_
LSC			LSC				LSC			
Reviewed E	By Reviewe	ed By	Date:	Signature of Sur	veyor:	ı			Date:	
State Agen	cy PS/AK		10/07/2014				2237	3	09/18	/2014
Reviewed E	By Reviewe	ed By	Date:	Signature of Sur	veyor:				Date:	
CMS RO										
Followup to Survey Completed on:			Check for any Uncor							
	7/25/2014			Uncorrected Defic	iencies (CM	S-256	or) Sent to the	e Facility?	YES	NO

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number 245554	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/15/2014
Name of Facility		Street Address, City, State, Zip Code	
RENVILLA HEALTH CENTER		205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	=

(Y4) Item	(Y	5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Prefix	F0309	Correction Completed 09/08/2014	ID Prefix		Correction Completed		ID Prefix		Correction Completed
Reg. # LSC	483.25	 	Reg. #				Reg. # LSC		<u> </u>
ID Prefix Reg. # LSC		Correction Completed	.		Correction Completed		ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed		ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed		ID Prefix Reg. # LSC		Correction Completed
Reg. #			Reg. #				ID Prefix Reg. # LSC		
Reviewed E	By Reviewe	ed By	Date:	Signature of Sur	vevor:			Date:	
State Agend		-	10/07/2014	2.3	-,		18623		5/2014
Reviewed E			Date:	Signature of Sur	veyor:		10023	Date:	<i>)</i> 2 014
Followup to	o Survey Completed of 7/25/2014	on:		Check for any Uncor Uncorrected Defic			es. Was a Summa 67) Sent to the Faci		NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: YFI9 Facility ID: 00557

MEDICARE/MEDICAID PROVIDE (L1) 245554 2.STATE VENDOR OR MEDICAID N (L2) 792697900	3. NAME AND AI (L3) RENVILLA (L4) 205 SOUTH (L5) RENVILLE	HEALTH CE EAST ELM A	ENTER	(L6) 56284	4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation 7. On-Site Visit	2. Recertification 4. CHOW 6. Complaint 9. Other			
5. EFFECTIVE DATE CHANGE OF 0 (L9) 07/01/2005 6. DATE OF SURVEY 07/25 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	OWNERSHIP 6/2014 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	OPPLIER CATEO 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	GORY 09 ESRD 10 NF 11 ICF/IID 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	8. Full Survey After of FISCAL YEAR ENDIN 09/30	Complaint		
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	56 (L18) 56 (L17)	Complianc 1. A B. Not in Con		gram	And/Or Approved Waivers Of	6. Scope of Serv 7. Medical Dire	vices Limit		
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 56 (L37) (L38)	WN 19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)			
16. STATE SURVEY AGENCY REM See attached Fire Safety Eva 17. SURVEYOR SIGNATURE Becky Wong, HFE NE II PAI 19. DETERMINATION OF ELIGIBIL	luation System	Date : COMPLETED I 20. COM	(L19)	18. STATE SURVEY AGENCY APPROVAL Anne Kleppe, Enforcement Specialist 09/11/2014 (L20) AL OFFICE OR SINGLE STATE AGENCY 21. 1. Statement of Financial Solvency (HCFA-2572)					
1. Facility is Eligible to F 2. Facility is not Eligible	-	RIGI	HTS ACT:		Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above :				
22. ORIGINAL DATE OF PARTICIPATION 04/01/1991 (L24)	23. LTC AGREED BEGINNING (L41)		4. LTC AGREEN ENDING DA (L25)		26. TERMINATION ACTION VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimburs	1 INVOLUN' 05-Fail to Morement 06-Fail to More	ACS (ACS) (A		
25. LTC EXTENSION DATE: (L27)	A. Suspension of Admissions: (L44)				03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	<u>OTHER</u>	Status Change		
28. TERMINATION DATE: 31. RO RECEIPT OF CMS-1539	(L28)	03001 DETERMINATION		(L31)	30. REMARKS Posted 09/16/2014 Co	0.			
	(L32)			(L33)	DETERMINATION APP	ROVAL			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	' IS CERTIFIED	AS:					
From (a): To (b):			nce With equirements e Based On:		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN	The Following Requirements: 6. Scope of Services Limit 7. Medical Director			
12.Total Facility Beds	56 (L18)	•	cceptable POC						
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14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS				
18 SNF 18/19 SNF 56	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)			
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION 1	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:			
Gloria Derfus, Supervisor		1	0/07/2014	(L19)	Anne Kleppe, Enforcement Specialist 10/07/2014(L20)				
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY			
19. DETERMINATION OF ELIGIBIDE _X 1. Facility is Eligible to F 2. Facility is not Eligible	Participate		IPLIANCE WITE HTS ACT:	H CIVIL	 21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : 				
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OF PARTICIPATION 04/01/1991	BEGINNING		ENDING DA		VOLUNTARY 00 01-Merger, Closure	. ,			
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25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER			
	B. Resema Se	ispension Bute.	(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS				
		03001							
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539		DETERMINATION 09/16/2014	OF APPROVAL	-					
	(L32)			(L33)	DETERMINATION APP	ROVAL			



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5554

Electronically Delivered: September 18, 2014

Ms. Cami Peterson-Devries, Administrator Renvilla Health Center 205 Southeast Elm Avenue Renville, Minnesota 56284

Dear Ms. Peterson-Devries:

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56 - Skilled Nursing Facility/Nursing Facility Beds

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Sincerely,

Dire Klegge

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program

Division of Compliance Monitoring

Minnesota Department of Health Email: anne.kleppe@state.mn.us

Telephone: (651) 201-4124 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: September 18, 2014

Ms. Cami Peterson-Devries, Administrator Renvilla Health Center 205 Southeast Elm Avenue Renville, Minnesota 56284

RE: Project Number S5554025

Dear Ms. Peterson-Devries:

On August 14, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 25, 2014. 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.

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Feel free to contact me if you have questions.

Sincerely,

Dire Klegge

Anne Kleppe, Enforcement Specialist

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(Y1)	Provider / Supplier / CLIA / Identification Number 245554	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/15/2014
Nam	e of Facility		Street Address, City, State, Zip Code	
RE	ENVILLA HEALTH CENTER		205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix Reg. # LSC	F0167 483.10(g)(1)		Correction Completed 09/08/2014	ID Prefix Reg. # LSC	F0225 483.13(c)(1)(ii)-(i		Correction Completed 09/08/2014			F0226 483.13(c)		Correction Completed 09/08/2014
ID Prefix Reg. # LSC	F0250 483.15(g)(1)		Correction Completed 09/08/2014	ID Prefix Reg. # LSC	F0272 483.20(b)(1)		Correction Completed 09/08/2014		ID Prefix Reg. # LSC	F0309 483.25		Correction Completed 09/08/2014
ID Prefix Reg. # LSC	F0323 483.25(h)		Correction Completed 08/20/2014	ID Prefix Reg. # LSC	F0353 483.30(a)		Correction Completed 09/02/2014			F0371 483.35(i)		Correction Completed 08/28/2014
ID Prefix Reg. # LSC			Correction Completed	Reg. #			Correction Completed					
ID Prefix Reg. # LSC				ID Prefix Reg. # LSC			Correction Completed					
Reviewed E	By R	eviewed	Ву	Date:	Signature	of Sur	vevor:				Date:	
State Agen		GD/AK	-	10/07/20	_	0. 0	,		18	3623		15/2014
	•	eviewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
Followup t	o Survey Comp 7/25/2		:		Check for any Uncorrecte					Summary o the Facility		NO

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245554	(Y2) Multiple Construction A. Building B. Wing 01 - MA	IN BUILDING 01	(Y3) Date of Revisit 9/18/2014
Name of Facility		Street Address, City, State, Zip Code	
RENVILLA HEALTH CENTER		205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	=

(Y4) Item	(Y	5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	()	(5) I	Date
		Correction Completed			Correction Completed					Correction Completed
ID Prefix		07/25/2014	ID Prefix				ID Prefix			-
•	NFPA 101	<u> </u>	Reg. #				Reg. #			_
LSC	K0072	_	LSC				LSC			=
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix			ID Prefix				ID Prefix			=
Reg. #		<u> </u>	Reg. #				Reg. #			_
LSC		_	LSC				LSC			-
		Correction			Correction					Correction
		Completed			Completed					Completed
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Reg. #		<u> </u>	Reg. #				Reg. #			_
LSC		_	LSC				LSC			=
		Correction			Correction					Correction
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LSC			LSC				LSC			=
		Correction			Correction					Correction
		Completed			Completed					Completed
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Reg. #		<u> </u>	Reg. #				Reg. #			_
LSC			LSC				LSC			
Reviewed E	By Reviewe	ed By	Date:	Signature of Sur	veyor:				Date:	
State Agen	cy PS/AK		10/07/2014				2237	3	09/18	/2014
Reviewed E	By Reviewe	ed By	Date:	Signature of Sur	veyor:				Date:	
CMS RO										
Followup t	o Survey Completed	on:		Check for any Uncor						
	7/25/2014			Uncorrected Defic	iencies (CM	S-256	or) Sent to the	e Facility?	YES	NO

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245554	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/15/2014
Name of Facility		Street Address, City, State, Zip Code	
RENVILLA HEALTH CENTER		205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	=

(Y4) Item	(Y	5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Prefix	F0309	Correction Completed 09/08/2014	ID Prefix		Correction Completed		ID Prefix		Correction Completed
Reg. # LSC	483.25	 	Reg. #				Reg. # LSC		<u> </u>
ID Prefix Reg. # LSC		Correction Completed	.		Correction Completed		ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed		ID Prefix Reg. # LSC		Correction Completed
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Reg. #			Reg. #				ID Prefix Reg. # LSC		
Reviewed E	By Reviewe	ed By	Date:	Signature of Sur	vevor:			Date:	
State Agend		-	10/07/2014	2.3	-,		18623		5/2014
Reviewed E			Date:	Signature of Sur	veyor:		10023	Date:	<i>)</i> 2 014
Followup to Survey Completed on: 7/25/2014			Check for any Uncor Uncorrected Defic			es. Was a Summa 67) Sent to the Faci		NO	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted August 14, 2014

Ms. Cami Peterson-Devries, Administrator Renvilla Health Center 205 Southeast Elm Avenue Renville, Minnesota 56284

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5554025

Dear Ms. Peterson-Devries:

The above facility was surveyed on July 21, 2014 through July 25, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5554004 and H5554005. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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 Department of Health orders being submitted 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 after the statement, "This Rule

Renvilla Health Center August 14, 2014 Page 2

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 me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring

Kumalu Fiske Downing

Minnesota Department of Health Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 10/03/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		СОМ	3) DATE SURVEY COMPLETED				
		245554	B. WING				C 25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER			20	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTHEAST ELM AVENUE ENVILLE, MN 56284	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309 SS=D	Each resident must provide the necessary or maintain the high mental, and psychological each of the second	CARE/SERVICES FOR EING receive and the facility must ary care and services to attain nest practicable physical, social well-being, in e comprehensive assessment	F3	609			9/8/14
	by: Based on interview failed to ensure app was implemented for who had skin break. The findings include R71 had been adm and had diagnosis in (DM) Type I, bacter hypothyroidism, dep The resident's recordocumentation of a The progress notes wound cultures of the Methicillin Resistant (MRSA). In addition, a progression the resident's riguinate indicated R71 his shoe off, and to gripper socks. Additional progression in the resident's riguinate indicated R71 his shoe off, and to gripper socks. Additional progression in the resident's riguinate indicated R71 his shoe off, and to gripper socks. Additional progression in the resident's riguinate in the resident's riguinate indicated R71 his shoe off, and to gripper socks. Additional progression in the resident's riguinate in the riguinate in the resident's riguinate in the rigui	itted to the facility on 2/22/10, including: Diabetes Mellitus ial infection, mood disorder, pression, and hypertension. In was reviewed and included reterial ulcers to the lower legs. Indicated that on 6/3/13, the left leg were positive for the Stapholoccos Aureus The sess note from 6/18/13, at the diabete and developed in the great toe. The progress had been educated to keep wear only TED stockings and tional documentation of the			Specific Resident R71: Resident record is considered in the constant of the c	nd the st ysis is d. . All utinely at the d and a he viewed ed	
ABCB 4====		nema noted on top of left foot,	LATI ID =		Monitor		(VC) DATE
ABORATOR\	CDIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	VALURE		TITLE		(X6) DATE

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

Electronically Signed

08/25/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245554	B. WING			07/2	2 5/2014
	PROVIDER OR SUPPLIER			20	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTHEAST ELM AVENUE EENVILLE, MN 56284	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 309	white swollen area toe/toenail, and od The record include resident's left foot 6/20/13-8/18/13. I progressive deterious wound. A progress note daindicated the left g declining skin state yellow in color with tip of left great toe circulation with no expected. Tip of rig which measured 0 closed. No change Treatment: keep a further indicated R open toed sandals On 7/31/13, the redocumented a prosignificant necrotic particularly the left indicated R71 had toes up to just beloblistered, denuded lateral mid (middle leg bones that end the notes included 5/31/13, were MRS treated with Bactro infection worsened Bactrim from 7/9-7 confused and had	er noted on top of left foot, is noted around left great or noted from left leg/foot. Index progress notes regarding the wound to the great toe from The notes reflected the pration in the condition of the left	F3	809	The Director of Nursing or designer review residents with wounds to enappropriate monitoring and care is completed based on wound care standards. Wound and clinical upon with interventions will be provided to the IDT. Chart audits will be core by the Directors of Nursing and/or designee to ensure appropriate interventions are in place. Perform Review Committee and Quality Ass. Committee will review results.	dates weekly npleted	

	AND DIAN OF CORRECTION IDENTIFICATION NUMBER			IPLE CONSTRUCTION NG		COMPLETED		
		245554	B. WING _		07	C /25/2014		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 309	the left leg does ca Percocet. Below the anesthesia was connote also included: cellulitis with periph what appears to be process in his big to A progress note da had been received R71's gangrenous Flagyl (an antibiotic crushed and sprink control. "Use 1 (one dressing change." The next progress foot was document The note indicated been changed at 7 dressing had been between the reside According to the nobut more maggots indicated when the multiple times, hos maggots and the he with R71's doctor. Another progress in p.m. indicated the he to the resident at 1 had reportedly spol physician and it had resident's foot then and coat with corn	y given his age and condition, use pain for which he receives e knee amputation with spinal nsidered" The physician's "ASSESSMENT/PLAN: MRSA peral vascular disease and a dry gangrene type of		09				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION			E SURVEY PLETED
		245554	B. WING			C 25/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	CODE	017.	20/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD E APPROPR	BE	(X5) COMPLETION DATE
F 309	record 8/27/13, at 4 "dressing change approximately 11:00 cleansed well befor and toes were kept dressing was fully it 8/25/13 prior to dre exposed, no draina minimal drainage, 2 gangrenous with tip well." The record dinvestigation or roo conducted to evaluate staff when complete order to determine gotten into the reside of the conducted to evaluate the conducted the conducted to evaluate the conducted to evaluate the conducted	vas made in the resident's 4:15 p.m., including: completed on 8/24/14 at 0, lower legs and toes re dressing applied, lower legs covered at all times and ntact on the morning of ssing change. No skin was ge coming through dressing; 2nd toe on left foot was fully of great toe gangrenous as lid not indicate further t cause analysis had been ate the techniques used by ing the dressing change in how the maggots might have	F3	09			

PRINTED: 10/03/2014 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER RENVILLA HEALTH CENTER SUMMARY STATEMENT OF DEPICIENCES (EACH DEPICIENCE) TAGO PRETIX TAGO INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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. A recertification survey was completed at the time of the standard survey. An investigation of complaint H5554004 was conducted. The complaint H5554004 was conducted to validate that substantiated. An investigation of complaint H5554004 was conducted. The complaint H5554004 was conducted. The complaint H5554004 was conducted to validate that substantiated the validate has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. ABBORATORY DRECTORS OR PROVIDERSUPPLIER REPRESENTATIVES SIGNATURE TITLE STATE TABOR STRUMENTS SIGNATURE STRUMENTS SIGNATURE STRUMENTS SIGNATURE STRUMENTS SIGNATURE STRUMENTS SIGNATURE STRUMENTS SIGNATURE STRUMENTS SIGNATURE SIGNATURE STRUMENTS SIGNATURE STRUMENTS SIGNATURE PREPRIES SIGNATURE STRUMENTS SIGNATURE PROPORTION STATE TAGO FREFIX TAGO FREFIX TAGO FREFIX T	-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
RENVILLA HEALTH CENTER 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284			245554	B. WING			07/	25/2014
FREERY TAG REGULATORY OR LSC IDENTIFYING INFORMATION) FOOD 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 with the regulations has been attained in accordance with your verification. A recertification survey was conducted form July 21st through July 25th 2014, and complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint H5554004 was conducted. The complaint was unsubstantiated. An investigation of complaint H5554004 was conducted. The complaint was unsubstantiated. An investigation of complaint H5554005, and was substantiated. A federal deficiency was issued as a result at F309. F167 SS=C READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal of State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.					20	05 SOUTHEAST ELM AVENUE		
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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 recertification survey was conducted from July 21st through July 25th 2014, and complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint H5554004 was conducted. The complaint was unsubstantiated. An investigation of complaint H5554005, and was substantiated. A federal deficiency was issued as a result at F309. F167 SS=C A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.		as your allegation of Department's acce enrolled in ePOC, y at the bottom of the form. Your electron be used as verifica	of compliance upon the ptance. Because you are your signature is not required e first page of the CMS-2567 ic submission of the POC will tion of compliance.					
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examination and must post in a place readily accessible to residents and must post a notice of their availability.		the most recent sur Federal or State su	rvey of the facility conducted by irveyors and any plan of					
	Apon	examination and m accessible to reside their availability.	ust post in a place readily lents and must post a notice of	IATUS.		T		(VO) PATE

Electronically Signed 08/25/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245554	B. WING		07/2	25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTHEAST ELM AVENUE RENVILLE, MN 56284		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 167	Continued From pa	ge 1	F 167			
	by: Based on observatoreview, the facility for results readily accessistors. This had the resident (R65) observed in the facility for the faci	a.m. and on 7/23/14, at 7:00 ok was observed to still be e counter at the South nurses' all and hidden by a flower vase, e and a sign-in/sign-out log p.m. when a family member at South nurses' station, F-J new where to find the MDH ults book, she stated she had in, when R65 moved close to of R65's head was below the survey results were not		Survey book is located in a central marked as Survey, adhered to wall chain and placed in a hanging file. Compliance will be monitored throuweekly maintenance rounds complethe maintenance director and/or de Staff will be educated on the import of ensuring survey results are avail residents, families, and any person comes to the facility.	by igh eted by signee. cance able to	

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING (X3)			DATE SURVEY COMPLETED		
		245554	B. WING		07/	25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 167		ge 2 ta Set (MDS) dated 7/17/14, led supervision to propel self	F 167			
F 225 SS=E	stated the facility al top of the counter a and verified the State partially hidden by a book. - At 7:45 a.m. the a book's proper place always close to the hooked by a chain administrator stated chain replaced. The annual survey results administrator, who policy as it was "a results administrator, who policy as it was a results administrator and results and results and results and results and results and report any know court of law against indicate unfitness for	facility's policy for posting the s was requested from the acknowledged there was no egulation." (c)(2) - (4) PORT DIVIDUALS It employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a tan employee, which would or service as a nurse aide or the State nurse aide registry	F 225			9/8/14

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		E SURVEY MPLETED	
		245554	B. WING		07/	/25/2014	
	PROVIDER OR SUPPLIER A HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 225	involving mistreatmincluding injuries of misappropriation of immediately to the to other officials in through established State survey and control of the facility must have a survey and control of the facility must have a survey and control of the facility must have a survey and control of the facility must have a survey and control of the facility must have a survey and the facility must have a survey and investigation is in part of the facility must have a survey and the facility must have a	nsure that all alleged violations nent, neglect, or abuse, funknown source and fresident property are reported administrator of the facility and accordance with State law diprocedures (including to the ertification agency). Ave evidence that all alleged aughly investigated, and must ential abuse while the progress.	F 2	25			
	by: Based on interview facility failed to immunknown origin for administrator and t (SA). In addition, the report alleged incide the SA, and to time of alleged abuse for the same of alleged of the same of alleged abuse for the same of	NT is not met as evidenced v and document review, the nediately report injuries of 1 of 1 resident (R29) to the he designated State agency he facility failed to immediately lents of abuse for R58, R59 to ally submit investigated reports or 4 of 5 residents (R23, R29, d during abuse prohibition.		Specific Resident #29: Resident reconstruction Resident #58: Reviewed and incident, investigation complimetry intervention put in place to a behavior. Care plan update Resident #59: Reviewed and incident, investigation complimetry ention put in place to a	d reported leted, address d. d reported leted,		

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245554	B. WING			07/2	25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTHEAST ELM AVENUE RENVILLE, MN 56284		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	and identified R29 foot/ankle, discolorarea and complaint and palpation. An opractitioner (NP)-D x-rayed to check fo completed on 1/21/have a non-displace metaphysis of the lesent to NP-D and N specific treatment foot cast splint was app 1/23/14, for immobility foot was then period weekend and elevate off of left foot. The was basically non-aexcept for restorative report indicated R2 stand-up lift and the during a transfer or stepped wrong and The report also indicated report and indicated report indicated R2 stand-up lift and the during a transfer or stepped wrong and the report also indicated report also in	-	F 2	225	behavior. Care plan updated. Resident #23: Vulnerable Adult log updated to track number of days from incident the investigation was filed a record auditing process. Identification All resident incidents within past 6 may person, or the source of the injurcannot be explained, or the injury is suspicious because of the extent of location. No other injuries were identified through behad documentation were reviewed to enappropriate reporting and assessmit were completed as indicated. Care were updated to reflect behaviors wappropriate interventions. Systemic Policy was reviewed and appropriate staff will be trained on policy to ensappropriate and timely reporting. Powill be followed. Monitor The Social Service Director and the Administrator or designee will monicompliance through monthly auditing Audits will be reviewed at Performan Review and Quality Assurance compliance com	months rved by ury f or ntified. avior nsure ents plans with te. All ure blicy	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTR IDENTIFICATION NUMBER: A. BUILDING			COMPLETI		
		245554	B. WING _		07/25/2	014
	PROVIDER OR SUPPLIER A HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF THE APPR DEFICIENCY)	JLD BE COM	(X5) IPLETION DATE
F 225	5/22/14, noted R29	num Data Set (MDS) dated had a score of 3 on the Brief I Status (BIMS) which	F 22	25		
	R58 was interviewed when asked the quanyone else here a verbal, physical or "Yes" to surveyor. FR58 to shut up two stated nurse assist aware of it as they time and R24 "has was asked, "Have being abused?" and	ly submission of reports: ed on 7/21/14, at 6:09 p.m. and estion, "Has staff, a resident or bused you-this includes sexual abuse?" R58 answered R58 stated R24 had yelled at different times. R58 also ants (NAs) and nurses were were in the dining room at the had a few talking's to." R58 you seen any resident here d R58 answered, "Yes", and ard R24 yell at other residents				
	scored a 15 of 15 of intact cognition. On 7/21/14, at 6:32 was asked whether yelling, RN-D answ social worker (SS)-yelling by different also stated when the were charted. At 6:37 p.m. SS-Asyelling at R58, and (VA) report regarding one for R24 yelling	dated 6/4/14, indicated R58 on the BIMS which indicated P. p.m. registered nurse (RN)-D restaff were aware of R24's ered "yes" and stated the A had been notified about the staff "more than once." RN-D hat happens R24's behaviors stated she was aware of R24's stated one vulnerable adulting R24 had been filed, but not at R58. SS-A stated she had R24 individually about the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245554	B. WING		07	/25/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284			
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F 225	yelling incident, but computer about it. own paper notes, a have documented aware R24 has yell stated R24 had der apologized after the time she had not co from R24 as verbal a long history toget submitted a report report was submitted was four days later. On 7/23/14, at 1:51 process was to talk investigate a little fi discuss, and then a to file a report to th or the administrato At 2:18 p.m. the adaware that reportate submitted immedia aware Investigative within five working verbal abuse from immediately to the On 7/24/14, at 9:55 loudly "two times a and staff. We were and redirect her. N. R24 then usually go out later. On 7/25/14, at 7:56 talked last night (or expressed feeling to the state of	had not put notes into the SS-A stated she only had her and said "Now I wish I would t." SS-A stated she was also ed at other residents. SS-A mentia, a "short fuse", and R24 incidents. SS-A stated at the onsidered the yelling incidents abuse as R58 and R24 have her. SS-A stated she had not to the SA. SS-A stated the ed to SA on 7/25/14, which p.m. SS-A stated the usual at to the staff or residents, rst, talk to the administrator, a decision was made whether e SA. SS-A stated either SS-A would make the report. ministrator stated yes she was ble Incidents should be tely to the SA, and was also a reports needed to be filed days of the incident. Report of R58 was not reported	F 22	5			

PROVIDER OR SUPPLIER	245554	B. WING				
		D. WING			07/2	25/2014
RENVILLA HEALTH CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTHEAST ELM AVENUE RENVILLE, MN 56284		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
the strap" if I yelled is R24's nature; R2 at people." SS-A als have put in the recombuse." SS-A stated the verbal between resident abuse. At 8:37 a.m. SS-A stated the verbal between resident abuse. At 8:37 a.m. SS-A stated the verbal between resident abuse. At 8:37 a.m. SS-A stated the verbal behavior when I talk to staff it At 9:09 a.m. SS-A prom Office of Health sent on 7/25/14, (coto Minnesota Departs aying she had filed regarding R24. Whereport, SS-A replied of the incident report the print button when At 9:12 a.m. SS-A stated the print button when At 9:12 a.m. SS-A stated the state	like R24 did. SS-A stated "that 4 has a gruff voice, and snaps so stated, "I wished I would ord [R58's] report of verbal d, "I haven't really focused on residents," but rather staff to said she had talked to staff ors, and stated, "but now it is a different story." provided a copy of the e-mail the Facility Complaints (OHFC) onfirmation of incident report ritment of Health (MDH), if an incident report last night en asked for the incident she could not provide a copy it as she had forgotten to push en submitting the report. Stated mental anguish was abuse, however, she had not erbal abuse. SS-A also stated icating the facility should	F 2	225			
scored a six on the had severely impair dated 2/14/14, by S vulnerable due to in the cognition impair completely express indicated R59 was a	BIMS which indicated R59 red cognition. A Progress note SS-A stated R59 was paired cognition and due to rment, R59 had some difficulty ing thoughts/words. The MDS able comprehend most					
	Continued From parthe strap" if I yelled is R24's nature; R2 at people." SS-A alshave put in the recabuse." SS-A stated the verbal between resident abuse. At 8:37 a.m. SS-A stated the verbal between resident abuse. At 8:37 a.m. SS-A stated the verbal between resident abuse. At 8:37 a.m. SS-A stated the verbal between resident abuse. At 9:09 a.m. SS-A prom Office of Health sent on 7/25/14, (coto Minnesota Departs aying she had filed regarding R24. Whereport, SS-A replied of the incident report the print button wheat 9:12 a.m. SS-A sconsidered verbal at been focusing on verbal at the provided person centresidents' felt.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 the strap" if I yelled like R24 did. SS-A stated "that is R24's nature; R24 has a gruff voice, and snaps at people." SS-A also stated, "I wished I would have put in the record [R58's] report of verbal abuse." 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R59's quarterly MDS, dated 5/1/14, indicated R59 had severely impaired cognition. A Progress note dated 2/14/14, by SS-A stated R59 was vulnerable due to impaired cognition and due to the cognition impairment, R59 had some difficulty completely expressing thoughts/words. The MDS indicated R59 was able comprehend most conversations if given time. R59 had diagnosis to include dementia.	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 the strap" if I yelled like R24 did. SS-A stated "that is R24's nature; R24 has a gruff voice, and snaps at people." SS-A also stated, "I wished I would have put in the record [R58's] report of verbal abuse." SS-A stated, "I haven't really focused on the verbal between residents," but rather staff to resident abuse. At 8:37 a.m. SS-A said she had talked to staff about R24's behaviors, and stated, "but now when I talk to staff it is a different story." 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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245554	B. WING _		07/	25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	,	
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F 225	and witnessed R24 down on the table. long standing histor was not clear if any between R24 and F have staff watch for R59 when together. On 7/23/14, at 1:50 to surveyor she four the morning of 6/24 she had talked to the incident and the adshould have submitt submitted on 6/25/1 R23's incident report 3/12/14, while transform wheel chair (without staff using on R23 fell hitting the framework door. R23 received The investigation for transfer while received as found staff had assisting R23 which fall. Staff was disciptraining on facility pransfer. The report injuries. The completed as completed days later. R23's Quarterly MD R23 had scored a staff had scored a staff had scored a staff had assisted as completed days later.	go. Staff members overheard yell and slam R24's hand The incident report identified a ry between R24 and R59 and it thing physical happened R59. Follow up plan was to ragitation between R24 and p.m. the social worker stated and out about the incident on/14. The social worker stated a administrator about that ministrator had told her she tted a report. The report was	F 22	25		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245554	B. WING		07	/25/2014	
	PROVIDER OR SUPPLIER A HEALTH CENTER	,		STREET ADDRESS, CITY, STATE, ZIP COD 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284			
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F 225	"yes" she was awa should be submitted was also aware involved filed within five was also aware involved filed within filed the safeg federal and State most stringent. "Corposition Policy was altereated for a potential maltreated filed	B p.m. the administrator stated re that reportable incidents of immediately to the SA, and restigative reports needed to working days of the incident. Sion Policy dated as provided to the stablished safeguards to the established safeguards to th	F 22	5			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	LE CONSTRUCTION (X3	(X3) DATE SURVEY COMPLETED	
		245554	B. WING		07/25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	
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F 225 F 226 SS=E	notified of alleged a immediately. E. Following comwithin five (5) working submit a copy of the 483.13(c) DEVELO ABUSE/NEGLECT. The facility must depolicies and procedomistreatment, negleand misappropriation. This REQUIREMENT by: Based on interview facility failed to ope prohibition policy, where for the five resident. Findings Include: The Abuse Prohibit 7/13, identified St. Festablished safegua (Abuse or Neglect) our facility. The safe	ministrator must also be buse/neglect situations pletion of the investigation ng days, the facility must e investigation to MDH." P/IMPLMENT ETC POLICIES	F 226		ce, reed blan
	under A. states Def and Neglect: Defini maltreatment. (Phy	e Abuse Prohibition Policy initions of Maltreatment/Abuse		Resident #23: Vulnerable Adult log updated to track number of days from incident till the internal investigation not to be entered and record auditing process. Identification	eeds

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245554	B. WING			07/2	25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTHEAST ELM AVENUE RENVILLE, MN 56284		
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F 226	Exploitation, Reside The Reporting Med Revised/Amended Services will follow alleged maltreatmet facility, to the approby the most stringe state rules and state. A. The person ob a suspicious injury to a resident in the supervisor immedia appropriate facility. C. Each facility mabuse/neglect to M means as soon as 24 hours after discethis notice of receip on file with the incident of the incident	chanisms for Alleged Abuse 7/13 states St. Francis Health procedures for reporting ont of a VA residing in our opriate authorities, as required nt federal regulations and utes. serving or suspecting abuse or (this is a mandated reporter) facility must notify his/her ately, who will report to the staff. Just report any suspected DH immediately ('immediately' possible, but ought not exceed overy of the incident). Save of report from MDH. Keep it	F 2	226	System wide review of Abuse Proh Policy. Systemic Policy was reviewed and appropria staff trained on Abuse Prohibition Fto ensure appropriate and timely reporting. Policy will be followed. Monitor The Social Service Director and the Administrator or designee will mon compliance through monthly auditing Audits will be reviewed at Performan Review and Quality Assurance consumptions.	e itor ng.	

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
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F 226	R29 again reported and left foot was swas then periodica and elevated with r foot. The investigat non-ambulatory morestorative ambulatindicated R29 was and the injury could transfer or during a wrong and/or slight also indicated the inwhile in standing lift displaced from star procedure. Upon in "bumped into my for any incident. The memory impairmer an accurate historia to the SA one day I report was submitted the incident occurred." On 7/23/14, at 2:18 yes she was aware should be submitted was also aware investigated.	It pain on 1/18/14, of left foot wollen at the time. The left foot lly checked over the weekend elief. Shoe was left off of left tive report identified R29 was est of the time except for tion program. The report transferred with stand-up lift d have occurred during a ambulation if R29 stepped ty twisted his ankle. The report njury could have occurred to if R29 moved foot or foot was adding plate during transfer atterview, R29 stated someone oct." No witnesses were noted the report read dementia and an prevented R29 from being an. The initial report was made ater. The final investigative ed on 1/27/14, six days after	F 2	226			
	when asked the quanyone else here a verbal, physical or answered "Yes" to yelled at R58 to she also stated nurse a were aware of that	ed on 7/21/14, at 6:09 p.m. and estion "Has staff, a resident or abused you-this includes sexual abuse?" R58 surveyor. R58 stated R24 had ut up two different times. R58 assistants (NAs) and nurses as they were in the dining and R24 "has had a few talking's					

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	PROVIDER OR SUPPLIER A HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	,	
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F 226	to." R58 was asked here being abused and stated R58 overesidents "to shut uthe SA on 7/25/14, On 7/21/14, at 6:32 when asked wheth yelling, RN-D answ social worker (SS)-by different staff "m stated when that had charted. -At 6:37 p.m. SS-A R24's yelling at R5 adult (VA) report rebut not one for R24 she had talked to be the yelling incident, computer about it. own paper notes, a have documented aware R24 has yell stated R24 had deapologized after the time she had not cofrom R24 as verbal a long history toget at that time had not of rom R24 as verbal a long history toget at that time had not cofrom R24 as verbal a long history toget at that time had not cofrom R24 as verbal a long history toget at that time had not cofrom R24 as verbal a long history toget at that time had not cofrom R24 as verbal a long history toget at that time had not cofrom R24 as verbal a long history toget at that time had not cofrom R24 as verbal at the time had not cofrom R24 as verbal at the time had not cofrom R24 as verbal at the time had not cofrom R24 as verbal at the time had not cofrom R24 as verbal at the time had not cofrom R24 as verbal at the time had not cofrom R24 as verbal at the time had not cofrom R24 as verbal at the time had not cofrom R24 as verbal at the time had not cofrom R24 as verbal at the time had not cofrom R24 as verbal at the time had not cofrom R24 as verbal at the time had not cofrom R24 as verbal at the time had not cofrom R24 as verbal at the time had not cofform R24 as verbal at the time had not cofform R24 as verbal at the time had not cofform R24 as verbal at the time had not cofform R24 as verbal at the time had not cofform R24 as verbal at the time had not cofform R24 as verbal at the time had not cofform R24 as verbal at the time had not cofform R24 as verbal at the time had not cofform R24 as verbal at the time had not cofform R24 as verbal at the time had not cofform R24 as verbal at the time had not cofform R24 as verbal at the time had not cofform R24 as verbal at the time had not cofform R24 a	I "Have you seen any resident" and R58 answered "Yes", erheard R24 yell at other p." The report was called to	F 22	6		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245554	B. WING			07/	25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER			20	REET ADDRESS, CITY, STATE, ZIP CODE 5 SOUTHEAST ELM AVENUE ENVILLE, MN 56284	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	aware Investigative within five working or report of verbal abust immediately to the R59's Quarterly ME	reports needed to be filed days of the incident. The use from R58 was not reported SA regarding R24.	F 2	26			
	R59 as having impa note dated 2/14/14, vulnerable due to c cognition impairme completely express able to if given time	the BIMS which depicted aired cognition. A Progress by SS-A stated R59 was ognition and due to the nt R59 had some difficulty ing thoughts/words, but was comprehend most had a history of dementia.					
	head during bingo. witnessed R24 yell table. The incident standing history beinot clear if anything R24 and R59. Follooping bings.	ported R24 hit R59 on back of Staff members overheard and and slam R24's hand down on report stated there was a long tween R24 and R59 and it was a physical happened between w up plan was to have staff between R24 and R59 when					
	to surveyor she fou the morning of 6/24 she had talked to the incident and the ad should have submit submitted on 6/25/* - At 2:18 p.m. the a was aware that rep submitted immedia aware Investigative within five working of	p.m. the social worker stated nd out about the incident on 1/14. The social worker stated he administrator about that ministrator had told her she sted a report. The report was 14, two days later. dministrator stated yes she ortable Incidents should be tely to the SA, and was also reports needed to be filed days of the incident. The wed in five days but rather					

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F 226	Continued From pa	nge 15	F 22	6		
	while transferring we chair (w/c) to exercusing gait belt. R23 hitting the head on R23 received a mir investigation found transfer while receivas found staff had assisting R23 which fall. Staff was discipatraining on facility pransfer. The reportinjuries. The final in	ort stated R23 fell on 3/12/14, with staff assistance from wheel ise equipment without staff is lost balance and R23 fell arm rest of chair and door. For skin tear on left ear. The R23 lost balance during a wing assistance from staff. It is not used a gait belt while in may have prevented R23's colined and was given further procedure for assisting R23 to it stated R23 received minor investigative report was 1/14, which was nine days later.				
	stated she was hire adult (VA) policy was stated the usual proor residents, invest administrator, discumade whether to fil staff will call adminit, and the administ to be made, and eiwill make the report update the policy to administrator/SA, the administrator streport immediately to call the staff	p.m. the social worker (SS)-A ed in 2012 and the vulnerable as already in place. SS-A ocess was talking to the staff igate a little first, talk to the uss, and then the decision is e a report. SS-A stated night istrator and they will talk about rator will decide if a report was ther SS-A or the administrator t. SS-A stated she would be read to report immediately to the investigate. At 2:18 p.m. attacted staff were trained to if a suspicion of abuse, were rator immediately, and if any SA-A or administrator and one of it. The administrator stated if should documented why. The distaff were told if the				

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F 250 SS=D	report it. The admir trained on the proce The administrator of Abuse Prohibition F "maltreatment" instem "mistreatment" and corporate policy. The reportable incidents immediately to the simmediately to the	not available, they were to histrator stated staff were edure yearly at a minimum. erified the facility's current Policy used State terminology ead of the Federal terminology said the policy was a he administrator also verified is needed to be submitted SA and investigation reports within five working dates of the PISION OF MEDICALLY SERVICE	F 2			9/8/14	
	by: Based on observate review, the facility for medically-related so resident (R24) iden outbursts which affer Findings include: On 7/23/14, at 9:40 yell, "Don't sass at and V-A were at the about 20 feet away standing. V-A explaint."	NT is not met as evidenced ion, interview and document ailed to provide ocial services for 1 of 1 tified as having behavioral ected two residents (R58, R4). a.m. R24 was observed to me!" at a volunteer (V)-A. R24 e Centennial Circle Garden, from where surveyor was ined to R24 that empty ctivity table were for residents		Specific Resident #24: Assessment complidentify and address needs, behave monitoring in place, interventions including resident response to interventions in place, informed reand family of choices and ramificate staff trained on identifying and defescalating or potentially abusive situations. Care plan updated. Identification	vior sident tions,		

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F 250	in wheelchairs who However, in a stern reply, "Ok, I'll keep On 7/24/14, at 10:5 R58 and R4, both reverbally abusive. Risher mad and also in [measuring approximand pointer finger].' a dose of Ativan (arbecause of anxiety R24 yelled at every people names too. person with them lecrap." R4 stated it because of anxiety R34 yelled at every people names too. person with them lecrap." R4 stated it because of anxiety MD was cognitively intain R4's quarterly MD was cognitively intain R4's quarterly MDS had moderate cognitively intain R24 manifested becomes and mod	would be joining the activity. way R24 was observed to quiet!" 3 a.m. during interviews with esidents identified R24 to be 58 stated R24's yelling made hade R58 feel "about that high mately an inch between thumb r R58 added having to ask for hanti-anxiety medication) caused by R24. R58 stated body and had called other R58 stated, "I don't feel like a betting her get by with all that bothered her when R24 yelled as the dining table at her. S dated 6/4/14, indicated R58 ct. dated 6/26/14, indicated R4 itive impairment. rogress Notes By Resident 3/10/14 to 4/25/14, indicated havioral symptoms: es indicated R24 had as and wandering" and a te which depicted R24 as ith room change did hit out at easions, did become verbally	F 2	250	All resident behavior monitoring for reviewed to identify behaviors and comprehensively assessed and respecific interventions developed an planned. Care plans and care guid be updated as necessary. Systemic Policy was reviewed and appropriated Assessments will be completed per 3.0 Assessment Policy. A comprehence curate and standardized assessment resident is functional capacity the RAI manual and regulation will completed per policy. Monitor The Social Service Director and the Administrator or designee will monic compliance through monthly auditing Audits will be reviewed at Performan Review and Quality Assurance compliance c	offer sident d care les will te. The MDS ensive, ment of y, using be toring.	

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F 250	7/8/14, regarding R R24's admission M R24 had severe con Behavioral Sympton physical behavioral others (such as hitt verbal behavioral sy others (such as thre occurring 4 to 6 day the assessment perhad other behavioral towards others (such which occurred 1 to assessment period R24's Care Area As dated 3/17/14, indic were triggered on th Analysis of Findings Indicators of Behav dated 3/21/14, were documentation to e factors for the beha entered in the Care of the RIBS dated 3 allow for the best qu MDS had identified summary of R24's I not limited to identifi behaviors, potential and clinically related and strategies to ac specific behaviors. R24's current care 3/27/14, did not add	24's behaviors. DS, dated 3/17/14, indicated gnitive impairment. The ms section, indicated R24 had symptoms directed towards ing, kicking, pushing) and ymptoms directed towards eatening, screaming, cursing) ys, but less than daily during riod. The MDS identified R24 al symptoms not directed thas hitting or scratching self) of 3 days during the	F 2	250			

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F 250	dated 4/28/14, indicinclude cerebrovasipain, and insomnia include dementia un electronic medical rupdated on 7/24/14 R24's quarterly MD had severe cognitive Symptoms section physical behavioral others; had verbal betward others and between the vice clinically redeveloped to address and the vice clinically redeveloped to address an	cated R24 had diagnoses to cular disease, generalized and R24's diagnoses list did not not it it was added to the records diagnoses list when a fer surveyor intervention. S dated 6/6/14, indicated R24 re impairment. The Behavioral indicated R24 did not manifest symptoms directed toward behavioral symptoms directed behavioral symptoms not ers occurring 1 to 3 days tent period. Although the tified potential inprovement in e clinical record lacked related social services were ss the idenitifed behaviors.	F 2	250			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 250	14 years. V-A state R24 yelled at her w who were present in had yelled at some not done it "for a wl "other people" were stated R24 did yell repeated R24 did norning." V-A state [at the facility]" kneethey were reported behaviors had occur. On 7/24/14, at 9:55 stated R24 yelled loday" at other reside "We were told to try and re-direct her." At 10:30 a.m. hous she witnessed R24 "yesterday" when Raside from witnessi 7/23/14, information behaviors were head or what to do about At 11:00 a.m. NA-B yell or do anything twas "very short" to children came to the At 11:15 a.m. NA-C staff R24 would be would yell at others behaviors were beindocumented. At 11:30 a.m. NA-A residents during ac	volunteered in the facility for d she felt embarrassed when ithin earshot of other people in the area. V-A claimed R24 other people before, but had nile." When V-A was asked if e residents of the facility, V-A at some residents and ot yell for some time until, "this id she believed "all staff here w about R24's behaviors as to the staff when the irred "before." a.m. nursing assistant (NA)-H and calm [R24's name] down ekeeping staff (HK)-B stated yell at somebody once in about R24's verbally abusive and during meetings. HK-B did it was said during the meetings it. I stated had not witnessed R24 to anybody, but had heard R24 people and did not like when e facility. I stated hearing from other impatient during activities and . NA-C was not aware if	F 25	50		

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F 250	reported R24's behavior a registered nursibehaviors were beindocumented. At 11:40 a.m. regist observed R24 yell a activities, such as wiball." RN-A stated Rivincident regarding Fibehaviors, RN-A widown by talking. RN monitoring, nor docibehaviors. RN-A dean incident involving resident on 7/23/14. On 7/25/14, at 7:56 (DON)-B and the sowhen R24, "first got behavioral issues", not happened lately DON-B also stated new and had happed DON-B confirmed of R24's admission diagnoses list on 7/dementia as a diagnoses list on 7/dementia as R24 had den have behavioral iss DON-B confirmed to address R24's risk significant lists and registered	rvene. NA-A stated they had aviors to the nurse manager e. NA-A was not aware if any monitored and ered nurse (RN)-A stated had at other residents during when residents were "playing then residents and calm R24 land approach and calm R24 land approach and calm R24 land and receiving a report about graph the to facility had some however, the behaviors had a the social worker and land then the social worker and land to some the social was added to 24/14. DON-B stated adding land to some son 3/25/14, 4/29/14, DON-B confirmed dementia R24's latest quarterly (MDS), dated 6/6/14. DON-B mentia and had potential to use that may affect others. The med a behavioral problems. The med a behavioral care plan	F 2	50			

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F 250	was nothing in the behavior. The social been no report to hadded, "But now wild different story." At 9:08 a.m. the so were no incident reones that were prosaid she had not be resident abuse. During interview on and SW stated they who go to activities roommate/bathroor issues [with R24's linterviewed people R24 and R58 and ractivities person wahad not seen anyth hard of hearing and just her. We provid care." SW stated din the medical recoplan at the desk to yelling. SW explain calm down and the When asked when place, SW stated, "if the behavior plan care sheets, DON-the night before. When asked if abuthe SW stated staff centered care," and that if residents we staffed, the resident	cial worker confirmed there progress notes about R24's all worker stated there had er about R24's behavior, and nen I talk to staff, it is a cial worker indicated there ports involving R24, except the yided to the surveyors, and pen focusing on resident to a 7/25/14, at 8:10 a.m. DON-B y had interviewed all resident's	F 25				

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F 250	resident abuse, an At 8:26 a.m., SW s [vulnerable adult]" verbally reported at to the surveyor on conducted an inversallegation to the Syprinting the report have a copy of the finding out now that [R24's name] had table. There had be notes about behave R24, and now whe story." The facility's policy staff to use the Re (RAI) Process to "a The policy directed and utilizations gui Medicare and Medicare and Medicares and	age 23 e an example of resident to d I probably should." stated she had printed a "VA for R4 "last night" after R4 had lleged verbal abuse from R24 7/24/14. SW stated she stigation and reported the A, but had hit "send", before and investigation, so did not VA report. SW stated, "I am at staff have not told us that been yelling and pounding the een nothing in the progress ior, no reports made about n I talk to staff it is a different of dated 11/2/10, directed facility sident Assessment Indicator assess the resident's function." It to complete the MDS, CAA delines by the Centers for icaid Services (CMS) to not to identify problems and late care plan goals and	F2	250			
	RAI Process' Proc "completion of the completing further	e resident." Under the facility's edure number 7, the assessment process includes assessments for the care the MDS," and that there must					
	be a "summary state contributing factors why the resident has RAI process further Area Assessment anature of the condificators that affected care planning; factors	tement of the causal factors, sor complicating factors as to as the problem." The facility's or directed to complete a Care summary and describe: the tion; complications and risk d the decision to proceed to ors that must be considered in alized care plan interventions:					

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F 250 F 272 SS=D	Continued From pa and the need for re appropriate health p 483.20(b)(1) COMP ASSESSMENTS	ferrals or further evaluation by professionals.	F 2			9/8/14
	a comprehensive, a	nduct initially and periodically accurate, standardized sment of each resident's				
	resident assessment by the State. The and least the following: Identification and do Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-by Physical functioning Continence; Disease diagnosis and Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potential Documentation of state additional assessments as triggered by the Data Set (MDS); are	sident's needs, using the nt instrument (RAI) specified assessment must include at emographic information; patterns; peing; g and structural problems; and health conditions; all status; and procedures; summary information regarding asment performed on the care the completion of the Minimum				

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F 272	Continued From pa	ige 25	F 272			
	by: Based on observar review, the facility fassess physical and for 1 of 3 residents Findings include: R24's record was redated 3/17/14, indiccognitive impairmed section, identified Faymptoms directed hitting, kicking, pussymptoms directed threatening, screamed days, but less than period. The MDS is behavioral symptom (hitting or scratching the assessment periods assessment periods as a comparison of the periods of the p	essessment (CAA) summary cated behavioral symptoms of Comments and Analysis of the Review of Indicators of ms (RIBS) form dated 3/21/14, or CAA lacked documentation or unique risk factors for the ms. A comment entered in the rations section of the RIBS		Specific Resident #24: Assessment complet identify and address needs, behavior monitoring in place, interventions including resident response to interventions in place, informed resident family of choices and ramifications and family of choices and ramifications are plan updated. Identification All resident behavior monitoring formore reviewed to identify behaviors and comprehensively assessed and resident comprehensive assessments of resident is behavior summary process. Monitor The Social Service Director and the complete identification.	ident ons, sing ms offer ident d care	
	Care Plan Conside dated 3/21/14, inclu			The Social Service Director and the Administrator or designee will monit compliance through monthly auditin	tor	

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F 272	MDS identified the the assessment per behaviors was trigglacked evidence R2 assessed for the identification of the identification of the set of the identification of the set of the identification of the set of the identification of the identi	presence of behaviors during riod, and the CAA for ered, the clinical record 24 was comprehensively entified behaviors. a.m. the director of nursing ocial worker both verified R24 rehensively assessed for 11/2/10, indicated staff were to essessment Indicator (RAI) the resident's function." The omplete the MDS, CAA and es by the Centers for Medicare ces (CMS) to "assess the problems and formulate an goals and approaches for dition, under the facility RAI enumber 7, direction included: assessment process includes assessments for the care the MDS," and a "summary usal factors, contributing ting factors as to why the oblem." The facility's RAI enter that any care area ary describe: nature of the tions and risk factors that roceed to care planning; a considered in making plan interventions; and the further evaluation by	F 2	272	Audits will be reviewed at Performa Review and Quality Assurance con		
F 309 SS=D		CARE/SERVICES FOR	F 3	809			9/8/14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245554	B. WING			07/25/2014	
	PROVIDER OR SUPPLIER A HEALTH CENTER			205	REET ADDRESS, CITY, STATE, ZIP CODE S SOUTHEAST ELM AVENUE ENVILLE, MN 56284		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Each resident must provide the necessor maintain the high mental, and psychological each of the second seco	ge 27 receive and the facility must ary care and services to attain nest practicable physical, esocial well-being, in e comprehensive assessment	F 3	09			
	by: Based on interview failed to ensure app was implemented for	This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility ailed to ensure appropriate care and monitoring was implemented for 1 of 3 residents reviewed who had skin breakdown (R71). The findings include: 171 had been admitted to the facility on 2/22/10, and had diagnosis including: Diabetes Mellitus DM) Type I, bacterial infection, mood disorder, ypothyroidism, depression, and hypertension.			Specific Resident R71 : Resident record is o	closed.	
	R71 had been adm and had diagnosis (DM) Type I, bacter hypothyroidism, de				All residents who are receiving wou care will be reviewed to ensure that level of care is provided at its higher potential and that a root cause and completed regarding cause of would	t the est lysis is	
	documentation of a The progress notes wound cultures of th Methicillin Resistan (MRSA). In addition, a progre 12:08 p.m. indicate on the resident's rig note indicated R71 his shoe off, and to gripper socks. Addi foot described eryth a small intact bliste	rd was reviewed and included rterial ulcers to the lower legs. indicated that on 6/3/13, he left leg were positive for t Stapholoccos Aureus ess note from 6/18/13, at d a small sore had developed that great toe. The progress had been educated to keep wear only TED stockings and tional documentation of the nema noted on top of left foot, in noted around left great		Wound care policies were re residents with wound care we reviewed with updates to en appropriate nursing care is proot cause analysis is composkin and wound protocols we and education provided to a nursing staff. Wound round completed weekly. Monitor The Director of Nursing or designed weekly.		outinely at the d and a The viewed sed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245554	B. WING		07/2	25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPOLICIENCY)) BE	(X5) COMPLETION DATE
F 309	The record includeresident's left foot of 6/20/13-8/18/13. The progressive deterior wound. A progress note daindicated the left gradeclining skin statuyellow in color with tip of left great toe circulation with no expected. Tip of rigwhich measured 0. closed. No change Treatment: keep alfurther indicated Ropen toed sandals. On 7/31/13, the residucumented a programment of the particularly the left indicated R71 had toes up to just beloblistered, denuded lateral mid (middle)	d progress notes regarding the wound to the great toe from he notes reflected the ration in the condition of the ted 7/30/13, at 3:05 p.m. eat toe continued to show s with base on both nails moist appearance. "Color of cale white/yellow. Poor improvement noted or ht great toe had a small area 4 cm diameter. Area was since last week. Current pressure off areas." The note 71's family had purchased him	F 309	DEFICIENCY)	dates weekly mpleted	
	5/31/13, were MRS treated with Bactro infection worsened Bactrim from 7/9-7/confused and had a the last two months pursue angiograph	"The culture results from A in the left leg cellulitis and ban and Bactrim, however his and [R71] was re-treated with (19/13. [R71] appears more a decline in mental status in a treatment of the family has chosen not to by given his age and condition, use pain for which he receives				

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		245554	B. WING _			07/2	25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CONTROL OF SOUTHEAST ELM AVENUE RENVILLE, MN 56284	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E APPROPR	BE	(X5) COMPLETION DATE
F 309	anesthesia was cornote also included: cellulitis with periph what appears to be process in his big to A progress note dath had been received R71's gangrenous of Flagyl (an antibiotic crushed and sprink control. "Use 1 (one dressing change." The next progress of foot was document. The note indicated been changed at 7: dressing had been between the reside. According to the note but more maggots indicated when the multiple times, hosp maggots and the howith R71's doctor. Another progress of p.m. indicated the howith R71's doctor. Another progress of physician and it had reportedly spoke physician and it had resident's foot then and coat with corn shad been done, and removed no more removed no more removed.	e knee amputation with spinal nsidered" The physician's "ASSESSMENT/PLAN: MRSA eral vascular disease and a dry gangrene type of	F 3	09			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245554	B. WING			07/25/2014	
	PROVIDER OR SUPPLIER A HEALTH CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTHEAST ELM AVENUE RENVILLE, MN 56284		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	approximately 11:00 cleansed well befor and toes were kept dressing was fully in 8/25/13 prior to dresexposed, no drainage, 2 gangrenous with tip well." The record dinvestigation or roof conducted to evalua staff when completi order to determine gotten into the residual of the element of th	e:15 p.m., including: completed on 8/24/14 at 0, lower legs and toes e dressing applied, lower legs covered at all times and ntact on the morning of ssing change. No skin was ge coming through dressing; and toe on left foot was fully of great toe gangrenous as id not indicate further t cause analysis had been ate the techniques used by ng the dressing change in how the maggots might have dent's wound. ident's care plan was revised sis of bacterial infection with bly Ben Gay or icy hot around d left great toe to increase on BID (twice a day). Keep all Hospice to assess skin status is for signs of breakdown every ach wound care protocol as ill assess for pain and d prior to dressing change."	F3	809			
F 323 SS=D	ulcers on the lower information regarding development of ma 483.25(h) FREE OF HAZARDS/SUPER	VISION/DEVICES	F3	323			8/20/14
	The facility must en	sure that the resident					

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		E SURVEY PLETED
		245554	B. WING		07/	25/2014
	ROVIDER OR SUPPLIER A HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP COI 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	as is possible; and adequate supervisi prevent accidents.	ns as free of accident hazards each resident receives on and assistance devices to	F 3	23		
	by: Based on observareview the facility farmaintained in a saft bathroom assist bars for 7 of R43, R70, R58, and During an environm p.m. with the direct bathroom assist bars by the DM. Loose bathroom as approximately one were identified in a R65. R7 had an OT (occ Progress & Dischail which indicated R7 tasks utilizing grab Care plan dated 2/2	maintain safe bathroom 7 residents (R7, R65, R23,		Specific Resident # 7 : Resident asset determine need for assist bar grab bars in BR were evaluat tightened according to manu recommendations. Resident # 65: Resident asset determine need for assist bar grab bars in BR were evaluat tightened according to manu recommendations. Resident # 23: Resident asset determine need for assist bar grab bars in BR were evaluat tightened according to manu recommendations. Resident # 43: Resident asset determine need for assist bar grab bars in BR were evaluat tightened according to manu recommendations. Resident # 43: Resident asset determine need for assist bar grab bars in BR were evaluat tightened according to manu recommendations. Resident # 70: Resident asset determine need for assist bar determine need for assist bar	es. Resident ed and facture essed to	

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		245554	B. WING		07/2	5/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER		2	RENVILLE, MN 56284		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	assessment (CAA) had triggered for R 7/16/14, noted R7 R since admit with no R65's admission M R65 required exten and had severely in also revealed R65 R fracture prior to adr 5/29/14, indicated f plan dated 6/9/14, if falls. Loose bathroom as approximately one were identified in the R23's care plan date was at risk for falls. indicated falls had to quarterly MDS date required extensive had moderately impalso depicted R23 without an injury in Loose bathroom as approximately one were identified in the and R70. The assis leaning forward to f which was pulled of 1/2 inch. The right as a depicted R23 and R70. The assis leaning forward to f which was pulled of 1/2 inch. The right as a depicted R23 and R70. The assis leaning forward to f which was pulled of 1/2 inch. The right as a depicted R23 and R70. The assis leaning forward to f which was pulled of 1/2 inch. The right and R70. The right and R7	The corresponding care area dated 4/23/14, indicated falls 7. The quarterly MDS dated and fallen in the last 90 days or injury noted. DS dated 5/29/14, indicated sive assist of one for toilet use apaired cognition. The MDS and a history of falls with a mission. The CAA dated alls had triggered for R7. Care andicated R65 had potential for a sist bars moving to three inches back and forth are bathroom for R23. The CAAs dated 10/16/13, ariggered for R23. The CAAs dated 10/16/13, ariggered for R23. The d6/25/14, indicated R23 assist of one for toilet use and paired cognition. The MDS as having one fall in the facility the last 90 days. The case of the same and forth are shared bathroom for R43 at bar on the right side was it under a toilet paper holder at of the wall approximately assist bar was not at the same	F 323	,	sident d re to sident d re lity d loose acture be ney will re	
		de assist bar. DM verified the notch to be able to fit under der.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245554	B. WING _		07	/25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	, ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	R43's had an OT - Discharge Summar indicated R43 was utilizing grab bars r plan dated 2/25/14, injury. The annual R43 required exten and had intact cogr R43 had a fall in the without an injury. The indicated falls had to R70's nursing assist indicated R70 requit transfers, had short cueing and reminded Loose bathroom as approximately one were identified in a R63. R58's CAAs dated triggered for R58. The following and reminded R59 also noted R59 also no	Therapist Progress & Ty dated 10/17/13, which able to perform toileting tasks equiring supervision. Care indicated R43 was at risk for MDS dated 5/9/14, indicated sive assist of one for toileting nition. The MDS also noted a facility in the last 90 days he CAAs dated 5/9/14, riggered for R43. Stant team sheet (undated) ired extensive assist of two for a term memory loss, needing ers and was at risk for falls. Sists bars moving to three inches back and forth shared bathroom for R58 and the quarterly MDS dated a fall in the facility in the tan injury. Care plan dated 58 was at risk for falls. 4/24/14, indicated falls had R63's admission MDS dated R63 required assist of one for alls in the 90 days, and had a care plan dated 5/6/14,	F 32	23		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245554	B. WING _		07/	25/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284		20/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 323	for housekeeping is not check the bathr had Maintenance F clipboard kept behi front counter. DM s anyone to report a concerns. DM state every day and tried as possible. DM ve assist bars were not request forms. DM policy, but reviewed process at new em annually to all staff. During an interview registered nurse (R and should write do that any staff can rehousekeeping." RN brought up at safet hires and yearly ins R23, R43, R58 and for toileting. RN-B s R70 used the bathr. During an interview stated he was not sassist bars were in the assist bars are not, I installed new the same." During an interview stated she would as bathroom assist bad o get loose after tillook at them again	ssues and call lights and he did from assist bars. DM stated he depair Request Forms on a and the South nursing station stated the forms were for maintenance requests or and he looked at the clipboard to resolve any issues as soon rified the loose bathroom of on the maintenance repair stated he had no written at the maintenance request ployee orientation and and the maintenance issues and export issues, "even I-B stated the process was y meetings, orientation for new service. RN-B verified R7, R65, I R63 all used their bathrooms stated she "was not sure" if	F 32	23			

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 353 SS=E	tighten them or we of further stated, "them, we probably in 483.30(a) SUFFICII PER CARE PLANS The facility must had provide nursing and maintain the highest and psychosocial we determined by reside individual plans of of the facility must pronumbers of each of personnel on a 24-th care to all residents care plans: Except when waive section, licensed nupersonnel. Except when waive section, the facility in nurse to serve as a duty. This REQUIREMENT by: Based on observations.	enance if they are loose, they find something else for them." Maybe we should be checking need to be doing that." ENT 24-HR NURSING STAFF ENT 24-HR NURSING STAFF The state of the state	F 35	23		9/2/14
	9 residents (R43, R	13, R30, R42, R39, R58, R55, -identified insufficient staff to		The facility designee will review standard to ensure that there is sufficient nursing staff to provide appropriate resident care and services, adjusting	ent e	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	01/20/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 353	Continued From pa	ige 36	F 353		
	Findings include:			census, acuity and reallocating staff where appropriate.	
	7/21/14, indicated a	fing schedules from 4/30/14 to a pattern of short staffing, for sed mandated overtime (4		Identification	
	hours), or shifts reradministrator, who and staffing, was u were needed, what overtime was used short, what the turn many open FTE's (measure of how maplanned schedules at monthly quality in stated "check with had 44 falls from 30 shift, 22 falls on evenight shift; the administrator stated half for weekend shinto overtime hours	mained unfilled. The facility was in charge of scheduling nable to state what positions percentage of mandated, what percentage of shifts ran over percentage was, or how full time equivalents - a any jobs were needed to fill the an		The facility will review staffing daily each area to ensure that there is sufficient nursing staff to provide appropriate resident care and service adjusting with census, acuity and reallocating staff where appropriate. Systemic Staffing policies were reviewed. Min staffing requirement was defined. Spatterns will routinely be reviewed be Nursing Management team and the Directors of Nursing and/or Administ to ensure that there is sufficient staffor each area and that staff is appropriately reallocated to meet can needs when call-ins require it. Direct Nursing and/or designee will evaluated cares and call light response to ensure that there is sufficient staffor each area and that staff is appropriately reallocated to meet can needs when call-ins require it.	ces, imum taffing y trator fing are ctors of te ure
	time included: From 6/2/14-6/15/1 eleven day shift wo hours overtime (OT were mandated fou workers were mand From 6/16/14-6/29/ twelve day shift, ter night shift workers From 6/30/14-7/13/ fourteen days shift, mandated four hou	4, the schedule indicated rkers were mandated four. 7). Seven evening shift workers in hours OT, nine night shift dated four hours OT. 714, the schedule indicated in evening shift and thirteen were mandated four hours OT. 714, the schedule indicated indicated in evening shift and thirteen were mandated four hours OT. 714, the schedule indicated in evening shift were rs OT, and two night shift home before the end of the		that appropriate care is being provided Staff will be instructed to go the nurse supervisor for assistance as necessing Monitor Staffing patterns will be monitored be Administrator/ Directors of Nursing of designee, adjusting with census, act and reallocating staff where appropriate appropriate conducted to ensure resident nearemet. Performance Review Command Quality Assurance Committee with the committee of the committee of the committee of the conducted to the committee of the committee of the committee of the conducted to the committee of the committee of the conducted to the committee of the conducted to the committee of the conducted to t	ded. se sary. by the or uity riate. s will eds mittee

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	PROVIDER OR SUPPLIER A HEALTH CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTHEAST ELM AVENUE RENVILLE, MN 56284		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG				(X5) COMPLETION DATE
F 353	examples) noted be 4/2/14, DON-A (dires split the evening che 4/3/14 DON-B work charge nurse shift. 4/20/14, the facility evening shift, and a floor at 8:50 p.m. 4/21/14, the facility because TMA was 4/24/14, the facility 1 1/2 nursing assist 4/26/14, the facility shift, the day shift op.m. (4 hours OT), supervisor was pull 5/7/14, the facility w 5/12/14, day shift she scheduled so only schanges on the evento NA position and shift, 2 NA's split a 5/15/14 the facility medication aide (Trunits on day shift arresident fell from a 5/17/14, a nurse ca a 10 hour shift. a Tl (and then left an en and a night shift che 5/26/14, the facility short on the evenin night shift worked u The daily staffing shorovided.	y staffing sheets (some elow indicated: ector of nursing) and DON-B arge nurse shift. Seed four hours of evening worked short 1/2 NA on the a resident was found on the worked short on day shift, pulled to NA shift. worked short on evening shift tants worked short 1 NA on the day sharge nurse stayed until 7 because the evening ed to an open nurse shift. Forked short a TMA. Short 2 NA, (but had one float short 1), there were six ening shift, a TMA was pulled shifts were split, and on night	F	3353	review results.		

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		245554	B. WING _		07/	25/2014	
	PREFIX TAG (X4) ID PREFIX TAG (X4) ID CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 353 Continued From page 38 shift. on 6/3/14 two NA called in sick and were replated by one NA who worked the night shift and stay until 10:00 a.m. 6/6/14, a day shift NA, went home early, a evening NA came late and left early, the censure was 56 (full). 6/11/14 a day shift TMA was ill and replaced be evening shift TMA, who was replaced by an LI for 6 hours., a nursing assistant shift was splited resident fell from a chair or bed at 6:00 a.m 6/14/14, a evening TMA went home 1 hour earned an evening NA worked 7 hours (planned 8), are evening NA worked only 4 hours (planned 8), are evening NA worked reduced hours. (a total reduction of 19 hours with a census of 55/56. 6/16/14 a TMA was short on the day shift, the evening charge nurse shift was split, an NA shift was split was split was split, an NA shift was split was sp			STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284			
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 353	shift. on 6/3/14 two NA c by one NA who wor until 10:00 a.m. 6/6/14, a day shift I evening NA came I was 56 (full). 6/11/14 a day shift I evening shift TMA, for 6 hours., a nurs resident fell from a 6/14/14, a evening an evening NA worked 2 night shift NA wor evening NA worked 2 night shift NA wor eduction of 19 hou 6/16/14 a TMA was evening charge nur was split on evenin 6/17/14, an LPN wa nurse short on Nor was ill and not replate evening shift was of on North unit and w 6/18/14 A NA from TMA from South wa assigned on Mission separate assignme 6/20/14, one day sl hours, the restorati hours and then pull evening charge nur TMA was reduced of nurse worked an ex reduced by 5 hours 7/4/14, a day shift I hour shift) a evening evening NA worked	alled in sick and were replaced rked the night shift and stayed NA, went home early, a ate and left early, the census TMA was ill and replaced by a who was replaced by an LPN sing assistant shift was split, a chair or bed at 6:00 a.m TMA went home 1 hour early, ked 7 hours (planned 8), and a donly 4 hours (planned 8), and rked reduced hours. (a total ars with a census of 55/56. It is short on the day shift, the rese shift was split, an NA shift gs and nights. It is used as a TMA, leaving 1 th unit until 12:30, and an NA aced. An LPN from the hanged to 12:30 to 9:00 hours was not replaced after 9:00 North was pulled to South, a as pulled to North, an NA was an and North. (usually two ents). In a night shift charge ktra hour. It is night shift charge ktra hour. It is night shift tharge ktra hour. It is night shift NA was shift nor in the shift shift charge ktra hour. It is night shift NA was shift nor in the shift NA was shift nor in the shift NA was sh	F 35	3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER A HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 353	Residents interview insufficient staffing R43 had a quarterly dated 5/21/14, and Mental Status (BIM indicated no cognitie extensive assist of transfers, toilet use was supposed to be was occasionally in frequently incontine had to wait 20-30 m daytime. R13 had a significate and indicated a BIM indicated severe corequired extensive mobility, transfers a assist of one staff of frequently incontine a toilet training programme. R30 had a quarterly indicated a BIMS so no cognitive impair assist of two staff wand extensive assist and personal hygical Foley catheter for continent of bowel.	at 4:00 a.m. (split shift). yed in stage 1 impacted by included: y Minimum Data Set (MDS) indicated a Brief Interview for S) score of 13/15, which ve impairment, and required one staff with bed mobility, and personal hygiene. R43 e on a toileting program trial, continent of urine and ent of bowel. R43 stated she ninutes for assistance in the one staff with bed and toilet use; and extensive or personal hygiene. R13 was ent and was supposed to be on gram. R13 stated, "I think there p I sometimes wait a long of MDS dated 7/2/14, and core of 14/15, which indicated ment, and required extensive with transfers and toilet use; at of one staff for bed mobility ene. R30 had an indwelling obstruction and was always R30 stated at night and in the not enough help, and "they"	F 35	3		

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245554	B. WING			07/	25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER			205 SO	ADDRESS, CITY, STATE, ZIP CODE UTHEAST ELM AVENUE LLE, MN 56284	1 0	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 353	R42 had a quarterly indicated a BIMS si severe cognitive im extensive assist of transfers, toilet use staff for personal hy incontinent of urine of stool. R42 stated problems and shout time they get to me medicine for it, som because I like to he R39 had a quarterly indicated a BIMS si no cognitive impair assist of two staff w toilet use, and exterpersonal hygiene. Fand had decreased the toilet in a timely facility could have r myself and diaper, commode everyday p.m., but they are send cognitive impair assist of one staff hygiene. R58 stated 30 minutes or longer aides to come from was on a toileting princontinent. R58 had administrator about pad more than twice lounge chair was well assist of was well as the complete than twice lounge chair was well as the complete than twice lounge chair was well as the complete than twice lounge chair was well as the complete than twice lounge chair was well as the complete than twice lounge chair was well as the complete than twice lounge chair was well as the complete than twice lounge chair was well as the complete than twice lounge chair was well as the complete than twice lounge chair was well as the complete than twice lounge chair was well as the complete than twice lounge chair was well as the complete than twice lounge than	y MDS dated 6/30/14, and core of 7/15, which indicated pairment. R42 required two staff for bed mobility, and extensive assist of one ygiene, and was always and occasionally incontinent I she was having bladder Id have more help, "By the I am wet should be given the think I am a nuisance I pand they are busy." y MDS dated 7/11/14, and core of 13/15, which indicated ment. R39 required extensive yith bed mobility, transfers and insive assist of one staff for R39 was on a toileting program incontinence when taken to fashion. R39 stated the more help, "I have messed [I'm] supposed to use y between 3:30 p.m. and 3:45		553			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245554	B. WING _		07/	25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 353	for R58. R55 had a quarterly indicated a BIMS s moderate cognitive extensive assist of transfers and toilet R55 was occasional bladder. R55 stated to get to the bathroenough staff. I don'go really bad, usual evening it takes quere limited assist of one transfers and toilet R23 was frequently stated, "Sometimes the evenings." R50 had a 14 day I score of 13/15, whi impairment, and rewith bed mobility, to personal hygiene. For urine and rarely stated, "I think they basically it takes the who was working. I am not scared, but On 7/23/14, at 9:33 normally able to ge really busy answer sometimes the facility."	y MDS dated 6/13/14, and core of 11/15, which indicated impairment, and required one staff with bed mobility, use and personal hygiene. ally incontinent of bowel and d, "Sometimes I wait too long om, [I] don't think there is t want to wait for help, I had to lly get up in the night. In the ite a while to get a pill." y MDS dated 7/2/14, and core of 9/15, which indicated impairment, and required e staff with bed mobility, use and personal hygiene. In incontinent of urine. R23 a I wait 30 minutes for assist in MDS dated 7/7/14, a BIMS ch indicated no cognitive quired extensive assist of 2 ransfers, toilet use, and R50 was frequently incontinent incontinent of bowel. R50 reed more people at night, em a long time, depends on have not had an accident, I	F 35			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245554	B. WING			07/	/25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER			205 SOUT	DDRESS, CITY, STATE, ZIP CODE THEAST ELM AVENUE LE, MN 56284		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOUL COSS-REFERENCED TO THE APPROPERTIES OF THE PROPERTIES OF THE APPROPERTIES OF THE APPROPERTIES OF THE PROPERTIES OF THE APPROPERTIES OF THE PROPERTIES OF THE PROPERTIES OF THE APPROPERTIES OF THE PROPERTIES	D BE	(X5) COMPLETION DATE
F 353	"If your name was of [schedule] it means your 8 hour shift [m been staffing better you [the State agen On 7/25/14, at 9:00 staffer (TS) was int different codes use stated a circled shift over-time shift. TS sometimes went ho schedule sheets 3 I shifts). TS stated th nursing assistants (evening shift, and the person came in ear hours in the early mad worked short, but two to three months schedule) remained two staff short on night statement working frequently, although few months. On 7/25/14, at 9:22 could provide call lideleted them after the length of call lig and DON-B then in their needs were might logs she had nowhen asked what the was on, she stated 25 minutes. Although 15 the staff should be sheard the length of call liges and DON-B then in their needs were might logs she had nowhen asked what the was on, she stated 25 minutes. Although 15 the staff should be sheard the length of call liges and DON-B then in their needs were might logs she had nowhen asked what the was on, she stated 25 minutes. Although 15 the staff should be sheard the length of call liges and DON-B then in their needs were might logs she had nowhen asked what the was on, she stated 25 minutes. Although 15 the staff should be shoul	sircled on the time sheet s you have to stay 4 hours past andatory overtime]. They have in the last month, knowing		53			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245554	B. WING			07/2	25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTHEAST ELM AVENUE RENVILLE, MN 56284		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	whose call light was week), but had interpast when her call I On 7/25/14, at 11:0 (FM)-B of R65 requand stated her mothwould expect. (FM) noted on admission nursing home. (FM) facility how to care keeping it elevated, stated R65 did not I because she had not schedule. R65's he the resident's ears stated, "There were busy. One time at 1 still waiting for staff not had breakfast y that morning." On 7/25/14, at 11:1 verified mandated of facility and she did overtime, the perceipast when her call is the perc	did not interview the resident s on for 25 minutes (this rviewed this resident in the	F3	s53			
	open in the facility. On 7/25/14, at 12:3 corporate did two w for us, the staffing with the case mix index generally staff a 1-8 and never above 1-morning in IDT (intesthem do a root cause	5 the administrator stated reek statistics for us and track was determined by looking at which for us was .99, 3 ratio on days and evening, 10. Falls were reviewed every erdisciplinary team), "I have see analysis (RCA), and want to couple of days." The facility					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245554	B. WING			07/:	25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284		05 SOUTHEAST ELM AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 353	that time could not injuries, accidents, incidents. Staffing we meetings and mont "Because they talk and retention in QA stated the facility had balance staffing, had ensure charge covery shift. "We have extended until 8:00 problem, we are us one to ones use far to try to help keep roughly risers, we are as they occur." The weekend of the schwere posted and we needed. "We offer the shifts [even if not own discipline needed." On 7/25/14, at 1:00 director (HR) stated open shifts: 9 (considered full to 9 NA on the evening position, but had not 9 RN supervisor or to offer the position yet). The HR was unable the state of the supervisor or to offer the position yet).	quality assurance) process, at correlate staffing with falls/ or resident to resident was talked about at board thly performance reviews, about job openings, turnover, a monthly." The administrator ad done some things to try and ave changed the TMA's, and erage all over the building on the example of the point of the point of the example of the point of the p	F	353			
	administrator.	tod jou min flood to don the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		245554	B. WING		07/25/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	.,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 371 F 371 SS=F	The facility must - (1) Procure food fro considered satisfac authorities; and	ROCURE, //SERVE - SANITARY om sources approved or story by Federal, State or local distribute and serve food	F 371		8/28/14
	by: Based on observareview, the facility from sanitary conditions, procedures to promin the main kitchen and consistently metemperatures. This of 56 residents who out of the main kitchen the following include: During the kitchen the following was ordicary director (DEF Food storage: Flour and sugar present in length by 1 following was ordically director weeklight of the following was ordically director (DEF Food storage: Flour and sugar present in length by 1 following weeklight of the following was ordically director (DEF Food storage: Flour and sugar present in length by 1 following weeklight of the following was ordically director (DEF Food storage: Flour and sugar present in length by 1 following weeklight of the following was ordically director (DEF Food storage: Flour and sugar present in length by 1 following weeklight of the food storage: Flour and sugar present in length by 1 following weeklight of the food storage: Flour and sugar present in length by 1 following weeklight of the food storage: Flour and sugar present in length by 1 following weeklight of the food storage: Flour and sugar present in length by 1 following weeklight of the food storage: Flour and sugar present in length by 1 following weeklight of the food storage: Flour and sugar present in length by 1 following weeklight of the food storage: Flour and sugar present in length by 1 following weeklight of the food storage: Flour and sugar present in length by 1 following weeklight of the food storage weeklig	had the potential to affect 56 oresided in the facility and ate hen and/or kitchenette tour on 7/21/14, at 4:00 p.m. bserved and confirmed by the		Specific Food Storage: All food storage items descripted and frozen will be labeled and dated when opened and/or put into prostorage containers. All food storage areas were reviewed to ensure all food labeled appropriated. Policy was reviewed and is appropriate. Unclean Equipment: All equipment will properly wiped down and sanitized at the end of each shift. Policy and guidelines were reviewed and deemed appropriate. Equipment unab to be cleaned was replaced. Dishwasher temperature: Temperature will be taken twice daily. Policy was reviewed and is appropriate. Thermometer changes to the dishwash were made according to manufacture	and per lis be he he le

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245554	B. WING			07/2	25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP COI 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	handle of the cover was unclean and the the contents were personal in the dry storage containing dry cere opened or used by of food borne illnes. In the dry storage mix had been open or used by date nor plastic bag to prever illness. The Centennial Circ following: - three orange juice content dated. - two prune juice content dated; one not laber one tomato juice of dated; one not laber one tomato juice of dated). - one cranberry juic dated). - one tomato juice of dated one identified. Unclean equipment During tour on 7/23 observed and confiinate below the stainless table there was a hentire length of the back and forth. The particle buildup in a length of the two dowere stored. The free opens of the particle buildup in a length of the two dowere stored. The free opens of the particle free of the particle buildup in a length of the two dowere stored. The free opens of the particle buildup in a length of the two dowere stored. The free opens of the particle buildup in a length of the two dowere stored. The free opens of the particle buildup in a length of the two doweres stored. The free opens of the particle buildup in a length of the two doweres stored. The free opens of the particle buildup in a length of the two doweres of the particle buildup in a length of the two doweres of the particle buildup in a length of the two doweres of the particle buildup in a length of the two doweres of the particle buildup in a length of the two doweres of the particle buildup in a length of the two doweres of the particle buildup in a length of the two doweres of the particle buildup in a length of the two doweres of the particle buildup in a length of the two doweres of the particle buildup in a length of the two doweres of the particle buildup in a length of the two doweres of the particle buildup in a length of the partic	around the edges and front. The DD verified the cover e bins should be dated when out in the bins. area three plastic containers als were not dated with an date to prevent the possibility s. area, a six pound bag of cake ed, not dated with an opened estored in a sealed food-grade ent the possibility of food borne cle refrigerator contained the econtainers were not labeled entainers (one labeled, not led not dated). Intainers (one labeled, not led, not dated). Container (not labeled, not led, not dated). Container (labeled, not lified all juice containers should dand dated).	F3	371	Identification All staff will be trained on cleaning, labeling, and importance of dishwat temperatures. All equipment and containers were inspected to ensur proper cleaning can occur. Systemic Any new equipment will have a clear procedure established prior to being into use. Staff will be educated on importance of cleaning and sanitizing reporting any poor equipment or for preparation issues to the Food Service Director. Monitor Observational and written audits with done by the Food Service Director designee. Compliance will be mone by the Food Service Director, the Administrator and reviewed by the Performance Management Commit	aning g put the ng and od vices	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245554	B. WING _		07	//25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371	Dishwashing temper During the kitchen is the final rinse dishwasher to July, 2014 indicated July 2014: 30 of 62 temperatures were rinse temperatures Fahrenheit (F). In a temperature for final was 193/148, on 7/ wash temperatures were final rinse temperatures were final rinse temperatures were final rinse temperature below temperature logs where temperatures were temperatures were temperatures were temperatures at all. During interview on stated that she star and noticed staff was temperatures, so si	eratures: tour on 7/21/14, at 4:00 p.m. vasher temperature was per day (AM and PM). Review emperature logs for June and d the following: (48%) final rinse recorded; there were two final below 180 degrees addition the 7/4/14 recorded al rinse was 200/140, on 7/5/14 6/14 was 148/182, indicating below 150 degrees F. (18%) final rinse recorded; there were three tures below 180 degrees F. In 4 recorded temperature for (145/145, indicating a wash 150 degrees F. No other rere provided. of five final rinse temperatures F and 81 of 122 possible past 2 months for which not recorded and the DD and d not been recording the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245554	B. WING _		07/	25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 371	though, I believe the wash cycle temperatures on Juring interview on aide (DA) stated shatemperatures on Juring interview on aide (DA) stated shatemperatures on Juring interview of the management of the temperatures on Juring interview of the facility of	e lower temperatures are the atures, not the rinse and they gone. They were not recording a while. " 17/23/14, at 1:45 p.m. dietary he recorded the wash aly 5 and 6th because, "That is go before, but the last giving us sheets and then we mps for a long time after that." 17/2011 indicated "all foods he added to the package, is to be stored in the cooler, and the	F 37	71		
	Review of the facili Sanitation of Equip "Use a mild deterged drawers should be	ty Cabinets and Drawers - ment (undated) indicated, ent and water, removable removed and washed. Rinse rs with a clean sponge and				
	Temperatures (und temperatures daily	ty Recording of Dishmachine lated) indicated, "Record on 'Dishmachine Temperature e temperatures must be				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245554	B. WING			07/	25/2014	
	PROVIDER OR SUPPLIER A HEALTH CENTER			STREET AL 205 SOUT RENVILL	,			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((CR	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 371	immediatelyto en temperatures are p controlled, a log mu	attion of the Dietary Manager issure that the wash and rinse roperly monitored and list be completed by those who is in the dish washing process.	F3	71				

F5554022

PRINTED: 09/10/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 07/25/2014 245554 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 205 SOUTHEAST ELM AVENUE RENVILLA HEALTH CENTER RENVILLE, MN 56284 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY 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, on July 25, 2014. At the time of this survey, Building 01 of Renvilla Health 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 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

Electronically Signed

08/25/2014

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.

PRINTED: 09/10/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01				(X3) DATE SURVEY COMPLETED	
		245554	B. WING STREET ADDRESS, CITY, STATE, ZIP CODE				07/25/2014	
	PROVIDER OR SUPPLIER A HEALTH CENTER			205	SOUTHEAST ELM AVENUE NVILLE, MN 56284	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
K 000	By eMail to: Marian.Whitney@s THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defic 2. The actual, or p 3. The name and/oresponsible for corprevent a reoccurr Building 01 of Ren 1963, with building and 1993. This or facility is fully fire significant for the facility has a following the corridors which is department notifical to the corpression of the corridors which is department notifical to the corpression of the corpression	PRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done siency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency. villa Health Center was built in additions constructed in 1970 re-story with partial basement sprinkler protected. The original additions were determined to be struction. ire alarm system with smoke rridors and spaces open to the monitored for automatic fire ation. The facility has a of 56 beds and had a census of	KO	000				
K 072 SS=E	NOT MET as evide NFPA 101 LIFE SA Means of egress a of all obstructions use in the case of	at 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD are continuously maintained free or impediments to full instant fire or other emergency. No ations, or other objects obstruct	ΚC)72			7/25/14	

Event ID: YFI921

STATEMENT	CS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE	SURVEY PLETED
		245554	B. WING		VI - MAIN BOLDING UT	07/2	25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 05 SOUTHEAST ELM AVENUE RENVILLE, MN 56284		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICIENCY)) BE	(X5) COMPLETIO DATE
K 072		age 2 gress from, or visibility of exits.	Κű)72			
	Based on observa facility has corridor evacuation situatio interfere with the c	is not met as evidenced by: tion and a staff interview, the obstructions. In an emergency n, these obstructions could onvenient and effective ts, staff and visitors from the mpartment.			Corrected by successful passing Survey conducted July 25th, 2014		
	it was observed that A). Interior finish records walls in the 100 W diminished the wid The original corridors been reduced at valength of the corridors [between the alum lap siding on the oldown of 1/4-inches [between side to the frame of side].; B). Grab rails mound 100 Wing and 200 5-inches and 5 1/2 measured from the	ween 11:30 AM and 3:00 PM,					
	corrected if an FSI has an overall leve	Tag will not need to be ES can establish that the facility I of fire safety equivalent to E Life Safety Code, 2000					

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DAT COM	E SURVEY MPLETED		
		245554	B. WING		07.	/25/2014	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 072	Continued From paredition.	ge 3	K 0	72			

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

(X2) MULTIPLE CONSTRUCTION

PRINTED: 09/10/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 02 - 2008 RESIDENT WING ADDITION B. WING 245554 07/25/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 205 SOUTHEAST ELM AVENUE **RENVILLA HEALTH CENTER** RENVILLE, MN 56284 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 25, 2014. At the time of this survey. Building 02 of Renvilla Health Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. Building 02 of Renvilla Health Center consists of the 2008 resident wing addition. It is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. All resident rooms are equipped with automatic, interconnected smoke detection. The facility has a capacity of 56 beds and had a census of 56 at time of the survey. (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE 08/25/2014

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.

Electronically Signed

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

PRINTED: 08/14/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245554	B. WING				C 25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	CODE	<u> 077.</u>	23/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD E APPROPI	BE	(X5) COMPLETION DATE
F 000	as your allegation of Department's accept	of correction (POC) will serve of compliance upon the optance. Because you are	FO	000			
	at the bottom of the form. Your electron be used as verification	·					
	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with					
	21st through July 2	vey was conducted from July 5th 2014, and complaint re also completed at the time vey.					
	conducted. The cor	complaint H5554004 was mplaint was unsubstantiated.					
F 272 SS=D		complaint H5554005, and was deral deficiency was issued as PREHENSIVE	F 2	772			
	a comprehensive, a	enduct initially and periodically accurate, standardized sment of each resident's					
LAPORATOS:	resident assessme by the State. The a	e a comprehensive sident's needs, using the nt instrument (RAI) specified assessment must include at	LIATURE.	TITLE			(X6) DATE

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245554	B. WING			C 25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	1 077	23/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 272	Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-be Physical functioning Continence; Disease diagnosis Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potential Documentation of stee additional assessareas triggered by the Data Set (MDS); are	emographic information; r patterns; peing; g and structural problems; and health conditions; hal status; and procedures; summary information regarding asment performed on the care the completion of the Minimum	F 27	2		
	by: Based on observative review, the facility fassess physical and	NT is not met as evidenced tion, interview and document ailed to comprehensively d verbally abusive behaviors (R24) reviewed for behaviors.				
	Findings include:					
	R24's record was re	eviewed An admission MDS				

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		245554	B. WING _			/25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 272	cognitive impairme section, identified F symptoms directed hitting, kicking, pus symptoms directed threatening, screan days, but less than period. The MDS idehavioral symptom (hitting or scratching the assessment period. The MDS identified the Findings sections of Behavioral Symptom were left blank. The to explain causal of behavioral symptom Care Plan Consider dated 3/21/14, including the best quality of IMDS identified the the assessment period behaviors was trigglacked evidence R2 assessed for the identified the section of the identified evidence R2 assessed for the identified the identified the identified evidence R2 assessed for the identified the identified evidence R2 assessed for the ident	cated R24 had severe nt. The Behavioral Symptoms R24 had physical behavioral I towards others (such as shing) and verbal behavioral I towards others (such as ning, cursing) occurring 4 to 6 daily during the assessment dentified R24 had other ms not directed towards others ag self) occurring 1 to 3 days in wriod. Sesessment (CAA) summary cated behavioral symptoms of the Review of Indicators of ms (RIBS) form dated 3/21/14, or CAA lacked documentation or unique risk factors for the ms. A comment entered in the rations section of the RIBS uded: "Care plan to allow for ife." Although the admission presence of behaviors during priod, and the CAA for gered, the clinical record cated was comprehensively dentified behaviors. So a.m. the director of nursing ocial worker both verified R24 orehensively assessed for 11/2/10, indicated staff were to ssessment Indicator (RAI)	F 27	2		
		the resident's function." The omplete the MDS. CAA and				

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

PRINTED: 08/14/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		045554				С
		245554	B. WING		07	/25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE
F 309 SS=D	and Medicaid Servi resident to identify appropriate care plathe resident." In add Process' Procedure "completion of the acompleting further areas triggered on statement of the cafactors or complicar resident has the proprocess further direassessment summa condition; complica affect decision to plactors that must be individualized care need for referral or appropriate health planagement with the service or maintain the high mental, and psychological plan of care.	es by the Centers for Medicare ces (CMS) to "assess the problems and formulate an goals and approaches for dition, under the facility RAI enumber 7, direction included: assessment process includes assessments for the care the MDS," and a "summary usal factors, contributing ting factors as to why the oblem." The facility's RAI exted that any care area ary describe: nature of the tions and risk factors that roceed to care planning; a considered in making plan interventions; and the further evaluation by professionals. CARE/SERVICES FOR EING Treceive and the facility must ary care and services to attain nest practicable physical, psocial well-being, in a comprehensive assessment	F 2			
	by: Based on interview failed to ensure app	NT is not met as evidenced and record review the facility propriate care and monitoring or 1 of 3 residents reviewed adown (R71).				

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	CON	MPLETED
		245554	B. WING _			C /25/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284		120/2014
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 4	F 30	9		
	The findings includ	ə:				
	and had diagnosis (DM) Type I, bacter	itted to the facility on 2/22/10, including: Diabetes Mellitus ial infection, mood disorder, pression, and hypertension.				
	documentation of a The progress notes wound cultures of t	rd was reviewed and included rterial ulcers to the lower legs. indicated that on 6/3/13, he left leg were positive for t Stapholoccos Aureus				
	12:08 p.m. indicate on the resident's rig note indicated R71 his shoe off, and to gripper socks. Addi foot described eryth a small intact bliste white swollen areas	ess note from 6/18/13, at d a small sore had developed ght great toe. The progress had been educated to keep wear only TED stockings and tional documentation of the nema noted on top of left foot, or noted on top of left foot, so noted around left great or noted from left leg/foot.				
	resident's left foot v 6/20/13-8/18/13. T	d progress notes regarding the vound to the great toe from he notes reflected the ration in the condition of the				
	indicated the left gr declining skin statu yellow in color with tip of left great toe circulation with no i	ted 7/30/13, at 3:05 p.m. eat toe continued to show s with base on both nails moist appearance. "Color of pale white/yellow. Poor mprovement noted or ht great toe had a small area				

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245554	B. WING			07	C /25/2014	
	PROVIDER OR SUPPLIER				ESS, CITY, STATE, ZIP COI AST ELM AVENUE MN 56284		723/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORR H CORRECTIVE ACTION S -REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 309	closed. No change Treatment: keep all further indicated R7 open toed sandals. On 7/31/13, the rest documented a progsignificant necrotic particularly the left gindicated R71 had toes up to just below blistered, denuded lateral mid (middle) leg bones that end the notes included: 5/31/13, were MRS treated with Bactrol infection worsened Bactrim from 7/9-7/confused and had at the last two months pursue angiography the left leg does can Percocet. Below the anesthesia was cornote also included: cellulitis with periph what appears to be process in his big to A progress note dathad been received R71's gangrenous of the sandal sand	A cm diameter. Area was since last week. Current pressure off areas." The note 71's family had purchased him ident's primary physician had press note indicating R71 had changes to his toes, great toe. The physician's note erythema extending from his with the knee with some areas on the left anterior to tib-fib (tibia-fibula) area (lower at the knee joint). In addition, "The culture results from A in the left leg cellulitis and can and Bactrim, however his and [R71] was re-treated with 19/13. [R71] appears more a decline in mental status in an the family has chosen not to y given his age and condition, use pain for which he receives a knee amputation with spinal asidered" The physician's "ASSESSMENT/PLAN: MRSA eral vascular disease and a dry gangrene type of the on the left."	F 3	09				
	crushed and sprink) 500 mg (milligrams) to be led over the wound for odor e) 500 mg Flagyl tab for each						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245554	B. WING				C 25/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CIT 205 SOUTHEAST ELM RENVILLE, MN 562	A AVENUE	1 011	20/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	((EACH CORR	'S PLAN OF CORRECTIO ECTIVE ACTION SHOULD ENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	The next progress of foot was document. The note indicated been changed at 7: dressing had been between the reside. According to the nobut more maggots indicated when the multiple times, host maggots and the howith R71's doctor. Another progress of p.m. indicated the howith R71's doctor. Another progress of p.m. indicated the howith R71's doctor. Another progress of p.m. indicated the howith are portedly spot physician and it had resident's foot then and coat with corn shad been done, and removed no more of the howith R71's doctors of the howith R71's doctors of the nand coat with corn shad been done, and removed no more of the howith R71's doctors of the nand toes were kept dressing was fully in 8/25/13 prior to dreep dressing	note regarding the gangrenous ed on 8/25/13, at 7:48 a.m. the resident's dressing had 30 a.m. and when the removed maggots were noted nt's toes on left foot. Ite, the area had been cleaned had appeared. The note area had been cleaned bice had been informed of the pospice nurse was going to talk ote dated 8/25/13, at 2:46 hospice nurse had made a visit 1:00 a.m. The hospice nurse ten to the resident's primary dispense decided to soak the clean with hydrogen peroxide starch. The note indicated this dispense was maggots had been noted.		09			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245554	B. WING			C /25/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284	ZIP CODE	23/2014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 309	gotten into the residence on 8/29/13, the resto include a diagnosinterventions to appleft heel wounds an blood flow/circulation pressure off heels. and pressure points visit, hospice will terordered, hospice will medicate as needed. During interview with at 12:30 p.m. on 7/2 had a long history of ulcers on the lower information regarding.	-	F3	309		



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted August 14, 2014

Ms. Cami Peterson-Devries, Administrator Renvilla Health Center 205 Southeast Elm Avenue Renville, Minnesota 56284

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5554025

Dear Ms. Peterson-Devries:

The above facility was surveyed on July 21, 2014 through July 25, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5554004 and H5554005. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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 Department of Health orders being submitted 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 after the statement, "This Rule

Renvilla Health Center August 14, 2014 Page 2

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 me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring

Kumalu Fiske Downing

Minnesota Department of Health Telephone: (651) 201-4112

Fax: (651) 215-9697

Renvilla Health Center August 14, 2014 Page 3 Renvilla Health Center August 14, 2014 Page 4

(X6) DATE

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00557	B. WING		07/2	25/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
RENVIL	LA HEALTH CENTER		HEAST ELNE, MN 56284				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 830	Proper Nursing Car Subpart 1. Care in receive nursing care custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the resident must remain prefers to remain in This MN Requirements by: Based on interview failed to ensure appwas implemented for who had skin break The findings included R71 had been admit and had diagnosis in (DM) Type I, bacter hypothyroidism, dep The resident's record documentation of a The progress notes wound cultures of the Methicillin Resistant (MRSA). In addition, a progress.	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed. ent is not met as evidenced and record review the facility propriate care and monitoring or 1 of 3 residents reviewed down (R71).	2 830	Corrected by August 28th, 2014		8/28/14	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

08/25/14 **Electronically Signed**

TITLE

STATE FORM 6899 If continuation sheet 1 of 5 YFI911

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00557	B. WING			C 25/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
RENVILI	A HEALTH CENTER		THEAST ELM			
0(0.15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	E, MN 56284	PROVIDER'S PLAN OF CORRE	CTION	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE AP	HOULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 1	2 830			
	note indicated R71 his shoe off, and to gripper socks. Addit foot described eryth a small intact blister white swollen areas toe/toenail, and odd. The record included resident's left foot w 6/20/13-8/18/13.	tht great toe. The progress had been educated to keep wear only TED stockings and tional documentation of the nema noted on top of left foot, or noted around left great or noted from left leg/foot. If progress notes regarding the yound to the great toe from he notes reflected the ration in the condition of the				
	indicated the left grodeclining skin status yellow in color with tip of left great toe procirculation with no in expected. Tip of right which measured 0.4 closed. No change Treatment: keep all	red 7/30/13, at 3:05 p.m. eat toe continued to show s with base on both nails moist appearance. "Color of bale white/yellow. Poor mprovement noted or ht great toe had a small area 4 cm diameter. Area was since last week. Current pressure off areas." The note '1's family had purchased him				
	documented a prog significant necrotic particularly the left of indicated R71 had of toes up to just below blistered, denuded a lateral mid (middle) leg bones that end a the notes included: 5/31/13, were MRS	ident's primary physician had cress note indicating R71 had changes to his toes, great toe. The physician's note erythema extending from his w the knee with some areas on the left anterior to tib-fib (tibia-fibula) area (lower at the knee joint). In addition, "The culture results from A in the left leg cellulitis and ban and Bactrim, however his				

Minnesota Department of Health

STATE FORM 6899 YFI911 If continuation sheet 2 of 5

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00557	B. WING			C 2 5/2014
NAME OF	PROVIDER OR SUPPLIER		DDESS CITY S	STATE, ZIP CODE		0,2011
NAIVIE OF	PROVIDER OR SUPPLIER		THEAST ELM			
RENVILI	A HEALTH CENTER		E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T	ULD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 2	2 830			
	Bactrim from 7/9-7/ confused and had a the last two months pursue angiography the left leg does cau Percocet. Below the anesthesia was cor note also included: cellulitis with periph what appears to be process in his big to A progress note dat had been received to R71's gangrenous of Flagyl (an antibiotic crushed and sprinkly	and [R71] was re-treated with 19/13. [R71] appears more a decline in mental status in . The family has chosen not to given his age and condition, use pain for which he receives a knee amputation with spinal insidered" The physician's "ASSESSMENT/PLAN: MRSA eral vascular disease and a dry gangrene type of the on the left." Ted 8/18/13, indicated an order to modify the treatment to wound. The order was for 1500 mg (milligrams) to be led over the wound for odor exp 500 mg Flagyl tab for each				
	foot was documented the note indicated been changed at 7: dressing had been between the resider According to the no but more maggots hindicated when the multiple times, hosy maggots and the howith R71's doctor. Another progress no p.m. indicated the hit to the resident at 11 had reportedly spoke physician and it had	note regarding the gangrenous ed on 8/25/13, at 7:48 a.m. the resident's dressing had 30 a.m. and when the removed maggots were noted nt's toes on left foot. te, the area had been cleaned had appeared. The note area had been cleaned bice had been informed of the ospice nurse was going to talk ote dated 8/25/13, at 2:46 hospice nurse had made a visit 1:00 a.m. The hospice nurse ten to the resident's primary it been decided to soak the clean with hydrogen peroxide				

Minnesota Department of Health

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Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00557	B. WING		07/2	5/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RENVIL	LA HEALTH CENTER		HEAST ELNE, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	and coat with corn is had been done, and removed no more in a little with a little wit	starch. The note indicated this d when the dressing was naggots had been noted. Vas made in the resident's 15 p.m., including: completed on 8/24/14 at 0, lower legs and toes e dressing applied, lower legs covered at all times and ntact on the morning of ssing change. No skin was ge coming through dressing; and toe on left foot was fully of great toe gangrenous as id not indicate further to cause analysis had been attended to the techniques used by any the dressing change in how the maggots might have	2 830			

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Minnesota Department of Health STATE FORM

YFI911 If continuation sheet 4 of 5

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						;
		00557	B. WING			5/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RENVILI	LA HEALTH CENTER		HEAST ELN E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	SUGGESTED MET The administrator, could develop a pol integrity maintenan- ulcers. The adminis designee could pro- nurses regarding do physician notificatio administrative staff compliance.	THOD OF CORRECTION: director of nurses or designee licy and procedure for skin ce, wound care and pressure strator, director of nurses or vide education to licensed ocumentation of wounds, on and treatment. The or designee could audit for R CORRECTION: Twenty One	2 830			

Minnesota Department of Health

STATE FORM 6899 YFI911 If continuation sheet 5 of 5

(X6) DATE

Minnesota Department of Health

AND DI AN OF CORRECTION INDENTIFICATION NI IMBER		(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		00557	B. WING		07/25/2014
	PROVIDER OR SUPPLIER	205 SOUT	DRESS, CITY, S HEAST ELN E, MN 56284		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
2 000	In accordance with 144A.10, this corrected pursuant to a surve found that the deficit herein are not corrected shall I with a schedule of the Minnesota Departments of the Minnesota Departments of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated ducorrected. You may request a that may result from orders provided that the Department with notice of assessme.	nether a violation has been compliance with all rule provided at the tag alle number indicated below. In several items, failure to the items will be considered Lack of compliance upon my item of multi-part rule will ment of a fine even if the item uring the initial inspection was thearing on any assessments in non-compliance with these ta written request is made to non 15 days of receipt of a non-compliance.	2 000	Minnesota Department of Health is	
	the Minnesota Depa Informational Bullet http://www.health.st	in 14-01, available at attate.mn.us/divs/fpc/profinfo/infelicensing orders are		documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for I Homes.	to

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 08/25/14

TITLE

STATE FORM 6899 If continuation sheet 1 of 53 YFI911

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00557	B. WING		07/2	5/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RENVILI	A HEALTH CENTER		HEAST ELNE, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETE DATE
	you electronically. Is necessary for State enter the word "correct. You must then State licensure proceedings of the corrected prior to el Minnesota Department on July 21st - July 2 Department's staff, the following correction that you land identify the date. In addition, complaid completed at the time. An investigation of conducted, and was investigation of computation.	oth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the ent of Health. 25th 2014, surveyors of this visited the above provider and tion orders are issued. Our electronic plan of have reviewed these orders, e when they will be completed. Int investigation(s) were also ne of the recertification survey. Complaint H5554004 was a unsubstantiated. An aplaint H5554005, and was	2 000	The assigned tag number appears far left column entitled "ID Prefix The state statute/rule out of compl listed in the "Summary Statement of Deficiencies" column and replaces Comply" portion of the correction of This column also includes the finding which are in violation of the state is after the statement, "This Rule is not as evidence by." Following the sumfindings are the Suggested Method Correction and Time period for Complete Disregard The Fourth Column which States, "Provider's Plan of Correction." This applies of Federal Deficiencies only. Will appear on Each Page. There is no requirement to Submit a Plan of Correction States. There is no requirement to Submit a Plan of Correction States.	Fag." iance is of the "To order. ings statute not met veyors d of rrection. DING OF THIS	
2 540	Resident Assessment Subpart 1. Assessment conduct a compreheresident's needs, which capability to perform significant impairment nursing assessment Minnesota Statutes 15, may be used as resident assessment comprehensive resident.	ment. A nursing home must ensive assessment of each hich describes the resident's a daily life functions and ents in functional capacity. A t conducted according to section 148.171, subdivision a part of the comprehensive at. The results of the ident assessment must be view, and revise the resident's	2 540			9/8/14

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00557	B. WING		07/2	5/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RENVILL	A HEALTH CENTER		HEAST ELN			
(V4) ID	STIMMA DV STA		E, MN 56284			()/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 540	Continued From pa	ge 2	2 540			
	4658.0405. Subp. 2. Information comprehensive resinclude at least the A. medically demedical history; B. medical state C. physical and D. sensory and E. nutritional state F. special treate G. mental and H. discharge political dental conditions. L. cognitive state M. drug therapy N. resident presentations.	ion; ential; n potential; itus; v; and		Corrected by September 8th, 2014	4	
	review, the facility fassess physical and for 1 of 3 residents	ailed to comprehensively d verbally abusive behaviors (R24) reviewed for behaviors.		, , , , , , , , , , , , , , , , , , , ,		
	Findings include:					
	dated 3/17/14, indic cognitive impairmed section, identified R symptoms directed hitting, kicking, pus symptoms directed threatening, scream days, but less than	eviewed. An admission MDS cated R24 had severe nt. The Behavioral Symptoms R24 had physical behavioral towards others (such as hing) and verbal behavioral towards others (such as ning, cursing) occurring 4 to 6 daily during the assessment lentified R24 had other				

Minnesota Department of Health

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	7	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00557	B. WING		07/2	5/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RENVIL	A HEALTH CENTER		HEAST ELN E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 540	behavioral symptor (hitting or scratchin the assessment per R24's Care Area Asdated 3/17/14, indice were triggered. The Findings sections of Behavioral Symptor were left blank. The to explain causal or behavioral symptor Care Plan Consided dated 3/21/14, included the best quality of limples identified the the assessment per behaviors was trigglacked evidence R2 assessed for the identified the second of th	ns not directed towards others g self) occurring 1 to 3 days in riod. ssessment (CAA) summary cated behavioral symptoms a Comments and Analysis of if the Review of Indicators of ims (RIBS) form dated 3/21/14, a CAA lacked documentation runique risk factors for the ins. A comment entered in the rations section of the RIBS added: "Care plan to allow for fe." Although the admission presence of behaviors during riod, and the CAA for pered, the clinical record 24 was comprehensively	2 540			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			B. WING			
		00557			07/2	25/2014
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, § THEAST ELM	STATE, ZIP CODE		
RENVILL	A HEALTH CENTER		E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 540	resident has the proprocess further dire assessment summa condition; complicate affect decision to profectors that must be individualized care propropriate health pro	ting factors as to why the oblem." The facility's RAI acted that any care area ary describe: nature of the tions and risk factors that roceed to care planning; a considered in making plan interventions; and the further evaluation by professionals. THOD OF CORRECTION: sing and/or designee could dmission, a comprehensive ducted each resident's needs, a resident's capability to unctions and significant extional capacity. The director of a could monitor to assure that priately assessed to not in the dementia/memory	2 540			
2 800	MN Rule 4658.0510 Staffing requirement Subpart 1. Staffing home must have or number of qualified registered nurses, li nursing assistants to residents at all nurs in all buildings if mo	requirements. A nursing of duty at all times a sufficient nursing personnel, including icensed practical nurses, and o meet the needs of the les' stations, on all floors, and one than one building is lides relief duty, weekends,	2 800			8/21/14

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			(X3) DATE COMP	SURVEY LETED		
		00557	B. WING		07/2	5/2014
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
RENVILL	A HEALTH CENTER		HEAST ELN E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 5	2 800			
	by: Based on observati review, the facility f 9 residents (R43, R R23, R50) who self meet their needs.	ent is not met as evidenced ion, interview, and document ailed to meet the needs of 9 of 213, R30, R42, R39, R58, R55, identified insufficient staff to		Corrected August 21, 2014		
	Findings include:					
	7/21/14, indicated a which the facility us hours), or shifts renadministrator, who and staffing, was used short, what the turn many open FTE's (measure of how maplanned schedules at monthly quality n stated "check with I had 44 falls from 3/shift, 22 falls on evenight shift; the administrator stated	fing schedules from 4/30/14 to a pattern of short staffing, for sed mandated overtime (4 nained unfilled. The facility was in charge of scheduling nable to state what positions percentage of mandated, what percentage of shifts ran over percentage was, or how full time equivalents - a any jobs were needed to fill the 1. Although this was discussed neetings, the administrator numan resources." The facility (1/14-7/21/14, 9 falls on day ening shift, and 13 falls on inistrator stated the facility of day and did not find a not staffing and falls. The did the facility paid time and a nifts, even when staff were not in the staff were not				
	time included: From 6/2/14-6/15/1 eleven day shift wo hours overtime (OT	4, the schedule indicated rkers were mandated four 5). Seven evening shift workers ir hours OT, nine night shift				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL		(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER	A. BUILDING:	COMPLETED
00557	B. WING	07/25/2014
	REET ADDRESS, CITY, STATE, ZIP CODE	01720/2014
	5 SOUTHEAST ELM AVENUE	
RENVILLA HEALTH CENTER	NVILLE, MN 56284	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION		CTION SHOULD BE COMPLETE THE APPROPRIATE DATE
2 800 Continued From page 6 workers were mandated four hours OT. From 6/16/14-6/29/14, the schedule indicate twelve day shift, ten evening shift and thirter night shift workers were mandated four hour From 6/30/14-7/13/14, the schedule indicate fourteen days shift, nine evening shift were mandated four hours OT, and two night shift workers were sent home before the end of the eight hour shift. A review of the daily staffing sheets (some examples) noted below indicated: 4/2/14, DON-A (director of nursing) and DO split the evening charge nurse shift. 4/3/14 DON-B worked four hours of evening charge nurse shift. 4/20/14, the facility worked short 1/2 NA on evening shift, and a resident was found on the floor at 8:50 p.m. 4/21/14, the facility worked short on day shift because TMA was pulled to NA shift. 4/24/14, the facility worked short on evening 1/2 nursing assistants 4/26/14, the facility worked short 1 NA on the shift, the day shift charge nurse stayed until p.m. (4 hours OT), because the evening supervisor was pulled to an open nurse shift 5/7/14, the facility worked short a TMA. 5/12/14, day shift short 2 NA, (but had one for scheduled so only short 1), there were six changes on the evening shift, a TMA was put to NA position and shifts were split, and on it shift, 2 NA's split a shift. 5/15/14 the facility worked short a trained medication aide (TMA) who was split betwe units on day shift and evening shift, and a resident fell from a chair or bed at 7:45 p.m. 5/17/14, a nurse came in at 5:00 a.m. and was 10 hour shift, a TMA worked a 12 hour shift.	2 800 ed en rs OT. ed the he it, shift e day 7 tt. loat ulled night en vorked	CY)

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Minnesota Department of Health

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION	COMPI	SURVEY LETED
	00557	B. WING		07/2	5/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
RENVILLA HEALTH CENTER	205 SOUT	HEAST ELM	AVENUE		
KENVILLA HEALIT GENTER	RENVILLE	, MN 56284		ı	
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 800 Continued From page	e 7	2 800			
and a night shift charge 5/26/14, the facility we short on the evening so night shift worked until The daily staffing sheet provided. 5/29/14, the facility we shift. on 6/3/14 two NA called by one NA who worked until 10:00 a.m. 6/6/14, a day shift NA, evening NA came lated was 56 (full). 6/11/14 a day shift TMA, who for 6 hours., a nursing resident fell from a check of 14/14, a evening NA worked evening NA worked evening NA worked or 2 night shift NA worked reduction of 19 hours 6/16/14 a TMA was shevening charge nurse was split on evenings 6/17/14, an LPN was an unuse short on North and was ill and not replaced evening shift was charged in North unit and was 6/18/14 A NA from No TMA from South was assigned on Mission as separate assignments 6/20/14, one day shift hours, the restorative hours and then pulled	ge nurse shift was split. orked short on the day shift, shift, and one NA from the il 10:00 a.m. on the 27th. et for 5/28/14, was not orked short on the evening ed in sick and were replaced ed the night shift and stayed and left early, the census of the early and left early, the census of the early and left early and left early, and left early, and left early, the census of the early and left early and left early, and left early shift, the left early shift, the left early shift, and nights. I we have left early ear	2 800			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00557	B. WING		07/2	25/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RENVILI	LA HEALTH CENTER		THEAST ELN E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 800	nurse worked an exreduced by 5 hours 7/4/14, a day shift Nour shift) a evenin evening NA worked worked 7 hours, a rand an NA came in Residents interview insufficient staffing R43 had a quarterly dated 5/21/14, and Mental Status (BIM indicated no cogniti extensive assist of transfers, toilet use was supposed to be was occasionally in frequently incontine had to wait 20-30 m daytime. R13 had a significa and indicated a BIM indicated severe corequired extensive assist of one staff for frequently incontine a toilet training progshould be more hel time." R30 had a quarterly indicated a BIMS so no cognitive impair assist of two staff wand extensive assist of was staff wand extensive assist of two staff wand ext	tra hour. a night shift NA was NA worked until 7 p.m. (12 g TMA worked 6.25 hours, an 4.25 hours, a evening NA night shift NA worked 4 hours at 4:00 a.m. (split shift).				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00557	B. WING		07/2	25/2014
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 0112	.3/2014
	A HEALTH CENTER		THEAST ELW	,		
KENVILL			E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	Continued From pa	ige 9	2 800			
	continent of bowel.	obstruction and was always R30 stated at night and in the not enough help, and "they e."				
	indicated a BIMS so severe cognitive imextensive assist of transfers, toilet use staff for personal hydrocontinent of urine of stool. R42 stated problems and shout time they get to memedicine for it, some	y MDS dated 6/30/14, and core of 7/15, which indicated pairment. R42 required two staff for bed mobility, and extensive assist of one ygiene, and was always and occasionally incontinent dishe was having bladder all have more help, "By the part of the think I am a nuisance alp and they are busy."				
	indicated a BIMS sino cognitive impair assist of two staff with toilet use, and exterpersonal hygiene. From the toilet in a timely facility could have myself and diaper, commode everyday p.m., but they are sindicated a BIMS sino cognitive impair assist of one staff hygiene. R58 stated 30 minutes or long aides to come from was on a toileting p	y MDS dated 7/11/14, and core of 13/15, which indicated ment. R39 required extensive with bed mobility, transfers and nsive assist of one staff for R39 was on a toileting program I incontinence when taken to a fashion. R39 stated the more help, "I have messed [I'm] supposed to use a between 3:30 p.m. and 3:45 cometimes late." Ity MDS dated 6/13/14, and core of 15/15, which indicated ment, and required extensive toilet use and personal dishe sometimes had to wait er while waiting on the toilet for a the other side to assist. R58 corgram and was usually ad a discussion with the				

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-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00557	B. WING		07/2	25/2014	
	PROVIDER OR SUPPLIER LA HEALTH CENTER	205 SOUT	DRESS, CITY, S THEAST ELM E, MN 56284				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
2 800	administrator about pad more than twice lounge chair was w "The administrator of for R58. R55 had a quarterly indicated a BIMS of moderate cognitive extensive assist of transfers and toilet R55 was occasional bladder. R55 stated to get to the bathrough evening it takes quievening it t	changing her incontinence e a day, because her bedside et and needed to be cleaned, stated this was embarrassing" MDS dated 6/13/14, and core of 11/15, which indicated impairment, and required one staff with bed mobility, use and personal hygiene. Illy incontinent of bowel and the system of the	2 800				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		00557	B. WING		07/2	5/2014
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
RENVILL	A HEALTH CENTER		HEAST ELM E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
	sometimes the facil staff "really have to "If your name was of schedule] it means your 8 hour shift [m been staffing better you [the State agen On 7/25/14, at 9:00 staffer (TS) was into different codes use stated a circled shift over-time shift. TS is sometimes went ho schedule sheets 3 is shifts). TS stated the nursing assistants (evening shift, and the person came in early mad worked short, but two to three months schedule) remained two staff short on night statement working is frequently, although few months. On 7/25/14, at 9:22 could provide call liguand DON-B stated each the length of call liguand DON-B then into their needs were mulight logs she had now when asked what the staff short of the length of call siguand pools and pools she had now hasked what the staff short of the length of call liguand pools she had now hasked what the staff short of the length of call liguand pools she had now hasked what the staff short of the length of call liguand pools she had now hasked what the staff short of the length of call liguand pools she had now hasked what the staff short of the length of call liguand pools she had now hasked what the staff short of the length of the leng	ng call lights. NA-F stated lity was short staffed and the work as a team." NA-F stated, sircled on the time sheet you have to stay 4 hours past andatory overtime]. They have in the last month, knowing	2 800			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00557	B. WING		07/	25/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE			
RENVILI	LA HEALTH CENTER		THEAST ELM E, MN 56284				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE	
2 800	25 minutes. Althouginterviewed the staff DON-B stated she whose call light was week), but had interpast when her call I On 7/25/14, at 11:0 (FM)-B of R65 requand stated her moth would expect. (FM) noted on admission nursing home. (FM) facility how to care keeping it elevated, stated R65 did not I because she had not schedule. R65's heather esident's ears stated, "There were busy. One time at 1 still waiting for staff not had breakfast y that morning." On 7/25/14, at 11:12 verified mandated of facility and she did overtime, the percethe percent of turno open in the facility. On 7/25/14, at 12:3 corporate did two wfor us, the staffing with the case mix index generally staff a 1-8 and never above 1-morning in IDT (interpretable).	gh DON-B stated she f to see what happened, did not interview the resident s on for 25 minutes (this rviewed this resident in the					

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MILLIFOC	ita Department of He	ailli				
AND DIAN OF CODDECTION IDENTIFICATION NUMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00557	B. WING		07/25/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
			HEAST ELM	,		
RENVILL	A HEALTH CENTER		E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	hear back within a clooked at the QA (quantity that time could not injuries, accidents, incidents. Staffing was meetings and mont "Because they talk and retention in QA stated the facility has balance staffing, has ensure charge covery shift. "We have extended until 8:00 problem, we are us one to ones use far to try to help keep resulting the counties."	ge 13 couple of days." The facility uality assurance) process, at correlate staffing with falls/or resident to resident was talked about at board hly performance reviews, about job openings, turnover, amonthly." The administrator ad done some things to try and the changed the TMA's, and erage all over the building on the changed activity schedules, p.m. to help with the boredom ing the team approach. For mily, activities in the evenings esident's busy. We started an erson started coming in for the	2 800			
	early risers, we are as they occur." The weekend of the sch were posted and we needed. "We offer the shifts [even if not or discipline needed." On 7/25/14, at 1:00 director (HR) stated open shifts: 9 (considered full the second open shifts: 9 NA on the night open shifts: 9 NA on the evening open shifts: 9 NA on the evening open shifts: 10 NA on the evening open shifts: 11 NA on the evening open shifts: 12 NA on the evening open shifts: 13 NA on the evening open shifts: 14 NA on the evening open shifts: 15 NA on the evening open shifts: 16 NA on the evening open shifts: 17 NA on the evening open shifts: 18 NA on the evening open shifts: 19 NA on the evening open shifts: 19 NA on the evening open shifts: 10 NA on the evening open shifts: 10 NA on the evening open shifts: 11 NA on the evening open shifts: 12 NA on the evening open shifts: 13 NA on the evening open shifts: 14 NA on the evening open shifts: 15 NA on the evening open shifts: 16 NA on the evening open shifts: 17 NA on the evening open shifts: 18 NA on the evening open shifts: 18 NA on the evening open shifts: 19 NA on the evening open shifts: 19 NA on the evening open shifts: 10 NA on the evening open shifts: 10 NA on the evening open shifts: 11 NA on the evening open shifts: 12 NA on the evening open shifts: 13 NA on the evening open shifts: 14 NA on the evening open shifts: 15 NA on the evening open shifts: 16 NA on the evening open shifts: 17 NA on the evening open shifts: 18 NA on the evening open shifts: 18 NA on the evening open shifts: 28 NA on the evening open shifts: 29 NA on the evening open shifts: 20 NA on the evening open shifts: 20 NA on the evening open shifts: 21 NA on the evening open shifts: 22 NA on the evening open shifts: 23 NA on the evening open shifts: 24 NA on the evening open shifts: 25 NA on the evening open shifts: 26 NA on the evening open shifts: 27 NA on the evening open shifts: 28 NA on the evening open shifts: 29 NA on the evening open shifts: 20 NA on the evening o	always adjusting to the needs administrator verified the first redule was short, but shifts reekend, and mandate OT as time and 1/2 for all weekend vertime], add nurses or any p.m. the human resources of the facility had the following time) NA on the night shift.				

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-	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY OMPLETED	
		00557	B. WING		07/2	5/2014	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
RENVILL	A HEALTH CENTER		HEAST ELN E, MN 56284				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 800 2 830	SUGGESTED MET facility administrato review and revise p to assure adequate residents in a timely resident needs. A control the system to assurand residents are significant their higher mental, and psychological transfer of the system to assurant residents are significant to the system to assurant residents are significant to the system to assure the system that the system to assure th	HOD OF CORRECTION: The r or director of nursing could olicies and staffing schedules staff are available to assist manner and to meet all designated staff could monitor to cares are being delivered upported to achieve and est practicable physical,	2 800 2 830			8/28/14	
2 333	Proper Nursing Car Subpart 1. Care in receive nursing car- custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 000			0/20/14	
	by: Based on interview failed to ensure app	ent is not met as evidenced and record review the facility propriate care and monitoring or 1 of 3 residents reviewed down (R71).		Corrected by August 28th, 2014			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00557	B. WING		07/2	25/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RENVILL	A HEALTH CENTER		THEAST ELM E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	The findings included R71 had been admin and had diagnosis in (DM) Type I, bacter hypothyroidism, dep The resident's record documentation of a The progress notes wound cultures of the Methicillin Resistant (MRSA). In addition, a progrest 12:08 p.m. indicated on the resident's rignote indicated R71 his shoe off, and to gripper socks. Addit foot described erythas small intact blister white swollen areas toe/toenail, and odd. The record included resident's left foot with 6/20/13-8/18/13. The progressive deterior wound. A progress note data indicated the left great declining skin status yellow in color with tip of left great toe proceed. Tip of right in the progression of the progression with no in expected. Tip of right in the progression of the progression with the progressi	itted to the facility on 2/22/10, including: Diabetes Mellitus ial infection, mood disorder, pression, and hypertension. Indicated that on 6/3/13, included interial ulcers to the lower legs. Indicated that on 6/3/13, included interial ulcers to the lower legs. Indicated that on 6/3/13, included interial ulcers to the lower legs. Indicated that on 6/3/13, included interial ulcers to the lower legs. Indicated that on 6/3/13, at does a small sore had developed into great toe. The progress had been educated to keep wear only TED stockings and tional documentation of the interior in the demander of the interior in the great toe from left leg/foot. If progress notes regarding the round to the great toe from the interior in the condition of the interior	2 830	DEFICIENCY		
		4 cm diameter. Area was since last week. Current				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '		(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00557	B. WING		07/2	5/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RENVILL	A HEALTH CENTER		HEAST ELW E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 16	2 830			
		pressure off areas." The note '1's family had purchased him				
	documented a prog significant necrotic particularly the left gindicated R71 had et toes up to just below blistered, denuded lateral mid (middle) leg bones that end the notes included: 5/31/13, were MRS treated with Bactrot infection worsened Bactrim from 7/9-7/confused and had at the last two months pursue angiography the left leg does can Percocet. Below the anesthesia was cornote also included: cellulitis with periph what appears to be process in his big to A progress note dathad been received.	ident's primary physician had ress note indicating R71 had changes to his toes, great toe. The physician's note erythema extending from his w the knee with some areas on the left anterior to tib-fib (tibia-fibula) area (lower at the knee joint). In addition, "The culture results from A in the left leg cellulitis and oan and Bactrim, however his and [R71] was re-treated with 19/13. [R71] appears more a decline in mental status in a The family has chosen not to y given his age and condition, use pain for which he receives a knee amputation with spinal asidered" The physician's "ASSESSMENT/PLAN: MRSA eral vascular disease and a dry gangrene type of the on the left."				
	crushed and sprink control. "Use 1 (one dressing change." The next progress refoot was documented.) 500 mg (milligrams) to be led over the wound for odor e) 500 mg Flagyl tab for each note regarding the gangrenous ed on 8/25/13, at 7:48 a.m. the resident's dressing had				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00557	B. WING		07/2	25/2014
	PROVIDER OR SUPPLIER	205 SOUT	DRESS, CITY, S HEAST ELM E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	been changed at 7: dressing had been between the resider According to the no but more maggots indicated when the multiple times, hosp maggots and the howith R71's doctor. Another progress in p.m. indicated the howith R71's doctor. Another progress in p.m. indicated the howith R71's doctor. Another progress in p.m. indicated the howith resident at 11 had reportedly spoke physician and it had resident's foot then and coat with cornshad been done, and removed no more in Although an entry with record 8/27/13, at 4 "dressing change approximately 11:00 cleansed well befor and toes were kept dressing was fully in 8/25/13 prior to dresexposed, no drainal minimal drainage, 2 gangrenous with tip well." The record dinvestigation or roof conducted to evaluate staff when complete order to determine gotten into the residuent of the res	30 a.m. and when the removed maggots were noted nt's toes on left foot. te, the area had been cleaned had appeared. The note area had been cleaned bice had been informed of the ospice nurse was going to talk onto the note of the ospice nurse had made a visit when the resident's primary dispense had been decided to soak the clean with hydrogen peroxide starch. The note indicated this dispense had been noted. It is made in the resident's completed on 8/24/14 at the dispense of the complete on left foot was fully of great toe gangrenous as id not indicate further the cause analysis had been attended the dispense of the d	2 830			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00557	B. WING		07/2	5/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RENVILL	A HEALTH CENTER		HEAST ELW E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	interventions to appleft heel wounds an blood flow/circulatio pressure off heels. and pressure points visit, hospice will terordered, hospice will medicate as needed. During interview with at 12:30 p.m. on 7/2 had a long history of ulcers on the lower information regarding development of material surface of the administrator, of could develop a polintegrity maintenance ulcers. The administration designee could provinurses regarding do physician notification administrative staff compliance.	ge 18 Ily Ben Gay or icy hot around d left great toe to increase in BID (twice a day). Keep all Hospice to assess skin status for signs of breakdown every ach wound care protocol as ill assess for pain and d prior to dressing change." In director of nursing (DON)-B, 25/14, she verified the resident if ischemic toes, and stasis extremities. No additional ing the wound care, or ggots was provided. IHOD OF CORRECTION: director of nurses or designee icy and procedure for skin be, wound care and pressure iterator, director of nurses or vide education to licensed ocumentation of wounds, in and treatment. The or designee could audit for a CORRECTION: Twenty One	2 830			
21015	Requirements- Sar	Subp. 7 Dietary Staff nitary conditi conditions. Sanitary	21015			8/28/14
	procedures and cor	nditions must be maintained in dietary department at all				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00557	B. WING		07/2	5/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RENVILL	A HEALTH CENTER		HEAST ELM			
			E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	Continued From pa	ge 19	21015			
	This MN Requireme	ent is not met as evidenced				
	by: Based on observati review, the facility fa sanitary conditions, procedures to prom in the main kitchen and consistently mo temperatures. This of 56 residents who out of the main kitch refrigerator. Findings include: During the kitchen to the following was of dietary director (DD Food storage: - Flour and sugar p feet in length by 1 1 clear plastic top we or used by date to p borne illness. The	on, interview and document ailed to store food under follow equipment sanitation note sanitation and food safety and kitchenette refrigerator onitor dishwasher had the potential to affect 56 oresided in the facility and ate hen and/or kitchenette		Corrected by August 28st , 2014		
	handle of the cover was unclean and th the contents were p - In the dry storage containing dry ceres	. The DD verified the cover e bins should be dated when				
	of food borne illness - In the dry storage mix had been open or used by date nor plastic bag to preveillness.	s. area, a six pound bag of cake ed, not dated with an opened stored in a sealed food-grade ent the possibility of food borne				
	The Centennial Circ	cle refrigerator contained the				

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00557	B. WING		07/2	5/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	-	
RENVIL	RENVILLA HEALTH CENTER 205 SOU RENVILL			I AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	following: - three orange juice not dated two prune juice codated; one not labe two grape juice codated; one not labe one tomato juice odated) one cranberry juice dated) one cra	e containers were not labeled ontainers (one labeled, not led not dated). Ontainers (one labeled, not led, not dated). Ontainers (one labeled, not led, not dated). Ontainer (not labeled, not lee container (labeled, not lified all juice containers should dand dated. 11. 12. 13. 14. at 1:45 p.m. the following rmed by the DD: setel center food preparation eavy flaky rust buildup on the base where two doors slide ere was also a heavy food a crevice that is inside the bors where pots and pans ont of the doors had hardened er. The left side of the table and there was heavy dust and the electric receptacle. 15. 16. 17. 18. 18. 19. 19. 19. 19. 19. 19	21015			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00557	B. WING		07/	25/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
RENVILI	LA HEALTH CENTER		THEAST ELM E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21015	June 2014: 11 of 60 temperatures were final rinse temperat addition the 6/18/14 final rinse was 195/ temperature below temperature logs w There were a total of below 180 degrees opportunities in the temperatures were temperature logs w DA verified they had temperatures at all. During interview on stated that she star and noticed staff was temperatures, so should be shoul	below 150 degrees F. 0 (18%) final rinse recorded; there were three ures below 180 degrees F. In recorded temperature for 145/145, indicating a wash 150 degrees F. No other ere provided. of five final rinse temperatures F and 81 of 122 possible past 2 months for which not recorded at all. No other ere provided and the DD and d not been recording the 7/21/14 at 4:00 p.m. the DD ted at the facility in mid-June as not recording any ne implemented a temperature ey sometimes miss doing it e lower temperatures are the atures, not the rinse and they one. They were not recording				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00557	B. WING		07/2	5/2014
NAME OF PRO	OVIDER OR SUPPLIER		DRESS, CITY, S T HEAST ELM	STATE, ZIP CODE		
RENVILLA I	HEALTH CENTER		E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
st co be op the R. S. Wine R. S. "Under the Lo bring te co are to m. C. se TI	container and put in e labeled to what in pen container with pen container with pen container with a warm immediately. Sanitation (undate ith a warm sanitizing ecessary. " Leview of the facility anitation of Equiporal Jack a mild deterged rawers should be replayed any inaccurate rought to the attenned attelyto encontrolled, a log must re directly involved not in the Administrator and revise food service of food on a dervice of food on a derv	is removed from original a storage container it needs to it is and date opened and any out a opened date on it will be " y Shelves and Other Surfaces and indicated, "Wash surface and solution. Use a brush when by Cabinets and Drawers - ment (undated) indicated, and water, removable are moved and washed. Rinse as with a clean sponge and by Recording of Dishmachine ated) indicated, "Record on 'Dishmachine Temperature at temperatures must be attended in the Dietary Manager sure that the wash and rinse aroperly monitored and ast be completed by those who in the dish washing process. In the dish washing process. In the Dietician could review wice policies and procedures is served in a sanitary and the Dietician could review wice policies and procedures is served in a sanitary. The anager could monitor the	21015			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		00557	B. WING		07/2	25/2014
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RENVILL	A HEALTH CENTER		HEAST ELN E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 23	21426			
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control		21426			8/28/14
	maintain a comprehinfection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control plaunpaid employees, residents, and volume Health shall provide regarding implements	e provider must establish and nensive tuberculosis ogram according to the most is infection control guidelines distates Centers for Disease ation (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of the technical assistance intation of the guidelines.				
	by: Based on interview facility failed to ens screening was com admission for 2 of 5	and comment review, the ure tuberculosis (TB) pleted within 72 hours from 5 residents (R24, R65) from reviewed for TB screening.		Corrected August 28th, 2014		
	Findings include:					
	medical record lack TB completed for R	to facility on 3/10/14, the ked evidence of screening for k24. The first step TB test was 4 on 4/5/14, or 26 days after				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00557	B. WING		07/2	5/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER	205 SOUT	DRESS, CITY, S HEAST ELN E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	VE ACTION SHOULD BE ED TO THE APPROPRIATE	
21426	admission. R65 was admitted to medical record lack TB completed for Radministered to R63 after admission. On 7/24/14, at 8:02 (DON)-B, stated the TB screening in the software (Optimus) screening by the us DON-B verified the documentation to incompleted for R24. On 7/25/14, at 3:00 was no evidence in indicate TB screening The facility's policy did not provide director TB. SUGGESTED MET director of nursing (review, revise policion residents are screen be educated on the The DON or design system to ensure of the R65 admission.	o facility on 5/22/14, the ded evidence of screening for 65. The first step TB test was 5 on 5/30/14, eight (8) days a.m. the director of nursing are was no questionnaire for facility's new computer, so staff had to do TB are of the paper form, however, medical record lacked adicate TB screening was p.m. DON-A verified there R65's medical records to ng was completed for R65. on Tuberculosis dated 12/09, ctions for screening residents THOD OF CORRECTION: The DON) or designee could see and procedures to ensure ned for TB. Facility staff could se policies and procedures. ee could develop a monitoring	21426			
21485	MN Rule 4658.1005 Services;Admission	5 Subp. 3 Social History &Assessment	21485			9/8/14

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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
		00557	B. WING		07/2	5/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RENVILI	A HEALTH CENTER		HEAST ELN E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21485	Subp. 3. Admission psychosocial history completed for each after admission. The assessment must be related to the resided planning goals based and strengths and recomprehensive respart 4658.0400. The assessment must be clinical record. This MN Requirements by: Based on observation review, the facility from the facil	In history and assessment. A ry and assessment must be new resident within 14 days ne psychosocial history and contain sufficient information ent's condition to develop care ed on that resident's needs may be used as a part of the ident assessment required by e psychosocial history and be included in the resident's ent is not met as evidenced on, interview and document ailed to provide ocial services for 1 of 1 tified as having behavioral ected two residents (R58, R4). a.m. R24 was observed to me!" at a volunteer (V)-A. R24 of Centennial Circle Garden, from where surveyor was ined to R24 that empty civity table were for residents would be joining the activity. way R24 was observed to	21485	Corrected by September 8th, 2014	4	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00557	B. WING		07/2	25/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RENVILI	A HEALTH CENTER		ΓHEAST ELM E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21485	a dose of Ativan (ar because of anxiety R24 yelled at every people names too. person with them le crap." R4 stated it b. "you old bitch" acro R58's quarterly MD was cognitively inta R4's quarterly MDS had moderate cogn A review of R24's P forms entered from R24 manifested bel On 3/17/14, the not "elopement attempt physical therapy no being "very upset w nursing staff x2 occagitated with therap On 3/20/14, R24 wayelling at staff at tim thereafter lacked expeling at staff at tim thereafter la	n anti-anxiety medication) caused by R24. R58 stated body and had called other R58 stated, "I don't feel like a atting her get by with all that bothered her when R24 yelled as the dining table at her. S dated 6/4/14, indicated R58 ct. dated 6/26/14, indicated R4 itive impairment. rogress Notes By Resident 3/10/14 to 4/25/14, indicated navioral symptoms: es indicated R24 had and wandering" and a te which depicted R24 as ith room change did hit out at asions, did become verbally y," as noted to be "hitting and nes." The progress notes vidence to indicate R24's ns were being monitored. ments in the physician's 8/25/14, 4/29/14, 6/10/14 and	21485			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		7	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00557	B. WING		07/2	5/2014
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	0112	.5/2014
			HEAST ELN	,		
RENVILL	A HEALTH CENTER		E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21485	Continued From pa	ige 27	21485			
	had other behavior	al symptoms not directed ch as hitting or scratching self) 3 days during the				
	dated 3/17/14, indice were triggered on the Analysis of Findings Indicators of Behave dated 3/21/14, were documentation to effectors for the behaventered in the Care of the RIBS dated 3 allow for the best question of MDS had identified summary of R24's not limited to identification behaviors, potential and clinically related.	ssessment (CAA) summary, cated behavioral symptoms he MDS. The Comments and is sections of the Review of prioral Symptoms (RIBS) form the left blank. There was no explain causal or unique risk avioral symptoms. A comment is Plan Considerations section 3/21/14, read, "Care plan to utility of life." Although the behaviors, the CAAs lacked a behavioral status, including but fication of resident specific I antecedents to the behaviors, discoil service interventions didress the identified resident				
		plan dated as initiated on dress behavioral symptoms.				
	dated 4/28/14, indic include cerebrovas pain, and insomnia include dementia u electronic medical i	section of R24's face sheet cated R24 had diagnoses to cular disease, generalized. R24's diagnoses list did not ntil it was added to the records diagnoses list when a fater surveyor intervention.				
	had severe cognitive Symptoms section physical behavioral	S dated 6/6/14, indicated R24 re impairment. The Behavioral indicated R24 did not manifest symptoms directed toward behavioral symptoms directed				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00557	B. WING		07/2	25/2014
NAME OF PROVIDER OR	SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
RENVILLA HEALTH	CENTER		HEAST ELNE, MN 56284			
PREFIX (EACH	DEFICIENC	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
directed to during the quarterly in R24's behindered to developed. There were involved investigating two staff in the incided but agreed slammed noise. 2.) On 7/2 allegedly yet table toward behavioral table and sitting on the state of the	ners and loward oth assessmunt as	behavioral symptoms not ers occurring 1 to 3 days nent period. Although the tified potential inprovement in e clinical record lacked related social services were ess the idenitifed behaviors.	21485	BENOTY .		

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STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00557	B. WING		07/2	5/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
55000		205 SOUT	HEAST ELM	I AVENUE		
RENVILI	A HEALTH CENTER	RENVILLE	E, MN 56284	ļ.		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21485	5 Continued From page 29		21485			
	stated R24 yelled loday" at other reside "We were told to try and re-direct her." At 10:30 a.m. house she witnessed R24 "yesterday" when R aside from witnessi 7/23/14, information behaviors were hea not remember what or what to do about At 11:00 a.m. NA-B yell or do anything t was "very short" to children came to the At 11:15 a.m. NA-C staff R24 would be would yell at others behaviors were bein documented. At 11:30 a.m. NA-A residents during act NA-A stated other r and staff would inte reported R24's behaviors were bein documented. At 11:40 a.m. regist observed R24 yell a activities, such as w ball." RN-A stated R incident regarding R behaviors, RN-A wo down by talking. RN-	stated had not witnessed R24 o anybody, but had heard R24 people and did not like when e facility. stated hearing from other impatient during activities and. NA-C was not aware if ng monitored and stated R24 would yell at other tivities when R24 was upset. esidents would just keep quiet rvene. NA-A stated they had aviors to the nurse manager se. NA-A was not aware if				

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	<u>ita Department of He</u>	alth	_			
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
7.110 1 12 11	or contraction	BERTH 10/M TOTAL MBERT	A. BUILDING:			
		00557	B. WING		07/2	5/2014
					0112	3/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RENVILI	A HEALTH CENTER		HEAST ELN			
			E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21485	Continued From pa	ge 30	21485			
	behaviors. RN-A denied receiving a report about an incident involving R24 yelling at another resident on 7/23/14.					
	(DON)-B and the so when R24, "first got behavioral issues", not happened lately DON-B also stated new and had happed DON-B confirmed of R24's admission diagnoses list on 7/dementia as a diag the doctor's progres 6/10/14 and 7/8/14. was not included in Minimum Data Set stated R24 had der have behavioral iss DON-B confirmed that address R24's risk social worker confirms was put in place on At 8:27 a.m. the sowas nothing in the pubehavior. The social been no report to headded, "But now which different story." At 9:08 a.m. the sowas and the solution of the social worker confirms was put in place on the social worker confirms and the solution of the social worker to head the solution of the soluti	a.m., director of nursing ocial worker reported that it to facility had some however, the behaviors had it. The social worker and R24's yelling behavior was not ened, "way back when." dementia was not included in agnoses, and was added to 24/14. DON-B stated adding nosis for R24 was pulled from as notes on 3/25/14, 4/29/14, DON-B confirmed dementia R24's latest quarterly (MDS), dated 6/6/14. DON-B nentia and had potential to ues that may affect others. here was no care plan to for behavioral problems. The med a behavioral care plan 7/24/14. Cial worker confirmed there progress notes about R24's all worker stated there had er about R24's behavior, and nen I talk to staff, it is a cial worker indicated there ports involving R24, except the yided to the surveyors, and then focusing on resident to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						(3) DATE SURVEY COMPLETED	
		00557	B. WING		07/2	5/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
DENIVILI	A HEALTH CENTER	205 SOUT	HEAST ELN	I AVENUE			
KENVILI	LA HEALTH CENTER	RENVILLE	, MN 56284				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21485	roommate/bathroor issues [with R24's kinterviewed people R24 and R58 and ractivities person wahad not seen anyth hard of hearing and just her. We provide care." SW stated do in the medical recorplan at the desk to yelling. SW explaine calm down and the When asked when place, SW stated, "if the behavior plan care sheets, DON-It the night before. When asked if abust the SW stated staff centered care," and that if residents were staffed, the resident were not enough st stated, "I don't give resident abuse, and At 8:26 a.m., SW st [vulnerable adult]" for verbally reported alto the surveyor on conducted an investallegation to the SA printing the report and the surveyor on the finding out now that [R24's name] had be table. There had be notes about behaviores.	ge 31 In share, and stated "all had no behaviors]." SW said they who go to the activities with eceived no complaints, the is interviewed and said they ing. SW stated R24 was very I spoke very loudly, "That's e her with person centered ementia was on the chart and rds and there was a behavior remove R24 when she was ed to take R24 to her room to in let her rejoin the group. The plan had been put into lit's at the desk." When asked was on the nursing assistant is indicated it had been done see was covered in orientation, were told to provide "person I explained, with an example, re told the facility was short the would be fearful that there aff to care for them. SW an example of resident to it I probably should." rated she had printed a "VA or R4 "last night" after R4 had beged verbal abuse from R24 (7/24/14. SW stated she tigation and reported the indinvestigation, so did not varied to the progress or, no reports made about in I talk to staff it is a different	21485				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE SURVEY COMPLETED	
		00557	B. WING		07/2	5/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
RENVILI	A HEALTH CENTER		HEAST ELNE, MN 56284				
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE				
21485	story." The facility's policy staff to use the Res (RAI) Process to "a The policy directed and utilizations guid Medicare and Medi "assess the resident formulate appropria approaches for the RAI Process' Proce "completion of the acompleting further a areas triggered on the a "summary stat contributing factors why the resident hat RAI process further Area Assessment's nature of the condit factors that affected care planning; factor making an individual and the need for relappropriate health purpose or deto ensure resident be comprehensively as interventions are defacility staff could be and procedures. The or designee could consure ongoing contributions are defacility staff could be and procedures. The or designee could consure ongoing contributions are defacility staff could be and procedures.	dated 11/2/10, directed facility ident Assessment Indicator ssess the resident's function." to complete the MDS, CAA delines by the Centers for caid Services (CMS) to at to identify problems and ate care plan goals and resident." Under the facility's edure number 7, the assessment process includes assessments for the care the MDS," and that there must be ment of the causal factors, or complicating factors as to as the problem." The facility's redirected to complete a Care nummary and describe: the ion; complications and risk of the decision to proceed to one that must be considered in alized care plan interventions; ferrals or further evaluation by professionals. THOD OF CORRECTION: The all worker or designee could evelop policies and procedures behaviors are identified, assessed and resident specific eveloped and care planned. All the educated on these policies are administrator, social worker develop a monitoring system to	21485				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7.1. 20.123.1.10.			
		00557	B. WING		07/2	25/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RENVILL	A HEALTH CENTER		HEAST ELN E, MN 56284			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
21685	Subp. 2. Physical princluding walls, floor systems, and equipment continuous state of with regard to the howell-being of the research.	Subp. 2 Plant eration, & Maintenance plant. The physical plant, ors, ceilings, all furnishings, oment must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program.	21685			8/20/14
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure equipment was maintained in a safe working order, including bathroom assist bars, for 7 of 7 residents (R7, R65, R23, R43, R70, R58, R63).			Plant Housekeeping, Operation, 8 Maintenance: Corrected August 2 2014		
	Findings include:					
	The facility failed to maintain safe bathroom assist bars for 7 of 7 residents (R7, R65, R23, R43, R70, R58, and R63).					
	p.m. with the direct	nental tour on 7/24/14, at 2:15 or of maintenance (DM) loose rs were identified and verified				
	approximately one	sist bars which moved to three inches back and forth shared bathroom for R7 and				
	Progress & Dischar which indicated R7	upational therapist) - Therapist rge Summary dated 7/26/13, was able to perform toileting bars requiring standby assist.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			B. WING		07/05/0044	
		00557	B. WING		07/2	25/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RENVILI	A HEALTH CENTER		HEAST ELN E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21685	Care plan dated 2/2 for falls. R7's annual dated 4/23/14, indicassist of one for toi impaired cognition. assessment (CAA) had triggered for R7/16/14, noted R7 is since admit with no R65's admission MR65 required extension and had severely in also revealed R65 if fracture prior to admits of the severely in also revealed R65 if fracture prior to admits of the severely in also revealed R65 if fracture prior to admits of the severely in also revealed R65 if fracture prior to admits of the severely in also revealed R65 in falls. Loose bathroom as approximately one were identified in the severely in also depicted R23 awithout an injury in Loose bathroom as approximately one were identified in the and R70. The assist leaning forward to find the severely one were identified in the and R70. The assist leaning forward to find the severely one were identified in the and R70. The assist leaning forward to find the severely one were identified in the and R70. The assist leaning forward to find the severely one were identified in the and R70. The assist leaning forward to find the severely one were identified in the and R70. The assist leaning forward to find the severely one were identified in the and R70. The assist leaning forward to find the severely one were identified in the and R70. The assist leaning forward to find the severely in the sever	25/14, revealed R7 was at risk all minimum data set (MDS) cated R7 required extensive let use and had moderately. The corresponding care area dated 4/23/14, indicated falls 7. The quarterly MDS dated had fallen in the last 90 days or injury noted. DS dated 5/29/14, indicated sive assist of one for toilet use mpaired cognition. The MDS had a history of falls with a mission. The CAA dated alls had triggered for R7. Care ndicated R65 had potential for esist bars moving to three inches back and forth he bathroom for R23. The CAAs dated 10/16/13, triggered for R23. The CAAs dated 10/16/13, triggered for R23. The d6/25/14, indicated R23 assist of one for toilet use and paired cognition. The MDS having one fall in the facility the last 90 days.	21685			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00557	B. WING		07/2	5/2014
NAME OF PRO	VIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RENVILLA H	IEALTH CENTER		HEAST ELW E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
ba the R4 Dis inco uti pla inju R4 an R4 wit inco tra cu Lo ap we R5 trig 6/2 on MI las 7/7 R6 trig 4/2 toi inti	e toilet paper hold I3's had an OT - 1 Scharge Summary dicated R43 was a lizing grab bars re an dated 2/25/14, ury. The annual N I3 required extens d had intact cogn I3 had a fall in the thout an injury. Th dicated falls had to T0's nursing assist dicated R70 requirence insfers, had short eing and reminde cose bathroom assist proximately one to the identified in a second second second second I3. I38's CAAs dated 1 I39 CAAs dated 2 I39 CAAs dated 3 I39 CAAs dated 4 I39 CAAS da	notch to be able to fit under er. Therapist Progress & y dated 10/17/13, which able to perform toileting tasks equiring supervision. Care indicated R43 was at risk for MDS dated 5/9/14, indicated sive assist of one for toileting ition. The MDS also noted a facility in the last 90 days are CAAs dated 5/9/14, riggered for R43. Itant team sheet (undated) ared extensive assist of two for term memory loss, needing are and was at risk for falls. Italians sist bars moving the inches back and forth shared bathroom for R58 and a fall in the facility in the an injury. Care plan dated as was at risk for falls. Italians a fall in the facility in the an injury. Care plan dated as was at risk for falls. Italians a fall in the facility in the an injury. Care plan dated as was at risk for falls. Italians a fall in the facility in the an injury. Care plan dated as was at risk for falls. Italians a fall in the facility in the an injury. Care plan dated as was at risk for falls. Italians a fall in the facility in the an injury and the falls had a fall in the facility in the an injury. Care plan dated as a fall in the 90 days, and had a care plan dated 5/6/14,	21685			

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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		00557	B. WING		07/2	5/2014
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
RENVILL	A HEALTH CENTER		HEAST ELM E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	stated he did round for housekeeping is not check the bathrhad Maintenance R clipboard kept behir front counter. DM state every day and tried as possible. DM verassist bars were no request forms. DM policy, but reviewed process at new empannually to all staff. During an interview registered nurse (R and should write do that any staff can rehousekeeping." RN brought up at safety hires and yearly ins R23, R43, R58 and for toileting. RN-B s R70 used the bathred buring an interview stated he was not sassist bars were in the assist bars were in the same." During an interview stated she would as bathroom assist bar bathred same."	on 7/24/14, at 3:20 p.m. DM s one time per month to check sues and call lights and he did oom assist bars. DM stated he repair Request Forms on a and the South nursing station tated the forms were for maintenance requests or d he looked at the clipboard to resolve any issues as soon rified the loose bathroom at on the maintenance repair stated he had no written the maintenance request ployee orientation and on 7/25/14, at 8:41 a.m. N)-B stated staff were trained with maintenance issues and export issues, "even -B stated the process was a meetings, orientation for new ervice. RN-B verified R7, R65, R63 all used their bathrooms stated she "was not sure" if	21685			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00557	B. WING		07/2	25/2014
	PROVIDER OR SUPPLIER A HEALTH CENTER	205 SOUT	DRESS, CITY, S HEAST ELM E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21685 21990	their caseload and/will tell us or mainter tighten them or we off further stated, "them, we probably them, we probably them.	or, "Housekeeping or nursing enance if they are loose, they find something else for them." Maybe we should be checking need to be doing that." THOD FOR CORRECTION: and/or designee could develop gram to maintain a safe residents. The maintenance else could educate all appropriate //procedures, and monitor to impliance. R CORRECTION: Twenty-one	21685			9/8/14
	immediately make a entry point. Use of for the deaf or othe considered an oral point may not requiextent possible, the content to identify the caregiver, the naturnal treatment, any emaltreatment, the noreporter, the time, or incident, and any other reporter believes must be suspected malting reporter may disclosin section 13.02, and	g. A mandated reporter shall an oral report to the common a telecommunications device r similar device shall be report. The common entry re written reports. To the report must be of sufficient ne vulnerable adult, the e and extent of the suspected evidence of previous ame and address of the date, and location of the ther information that the light be helpful in investigating reatment. A mandated se not public data, as defined in medical records under the extent necessary to				

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			,			
		00557	B. WING		07/2	5/2014
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RENVILL	A HEALTH CENTER		HEAST ELN E, MN 56284			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
21990	Continued From pa	ge 38	21990			
	by: Based on interview facility failed to immunknown origin for administrator and the (SA). In addition, the report alleged incide to the SA, and to tir reports of alleged and the same state of the same state o	and document review, the nediately report injuries of 1 of 1 resident (R29) to the ne designated State agency e facility failed to immediately ents of abuse for R58 and R59 mely submit investigated buse for 4 of 5 residents (R23, riewed during abuse		Corrected by September 8th, 201	4	
	Findings Include:					
	Injury of unknown origin: 29's incident report, dated 1/21/14, was reviewed and identified R29 had swelling of the left foot/ankle, discoloration in left inner ankle/heel area and complaint of (c/o) pain with movement and palpation. An order was received from nurse practitioner (NP)-D for the foot and ankle to be x-rayed to check for injury. The x-ray was completed on 1/21/14, and R29 was found to have a non-displaced fracture of the distal metaphysis of the left fibula. The results were sent to NP-D and NP-D advised there was no specific treatment for that type of fracture. An air cast splint was applied on R29's left foot on 1/23/14, for immobilization and comfort.					
	noted to c/o pain or Resident again rep- foot and left foot wa foot was then perio weekend and eleva off of left foot. The	eport stated R29 had first in 1/16/14, located in the knee. orted pain on 1/18/14, of left as swollen at the time. The left dically checked over the inted with relief. Shoe was left investigative report stated R29				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00557	B. WING		07/2	07/25/2014	
				0772	3/2014	
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, S T HEAST ELN	TATE, ZIP CODE			
RENVILLA HEALTH CENTER		HEAST ELIVE, MN 56284				
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST E REGULATORY OR LSC IDEN	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE	
except for restorative ambreport indicated R29 was stand-up lift and the injury during a transfer or during stepped wrong and/or slig. The report also indicated occurred while in standing or foot was displaced from transfer procedure. Upon someone "bumped into m were noted for any incider dementia and memory im from being an accurate hi was made to the SA one of investigative was submitted after the incident occurred. The quarterly Minimum Dis 5/22/14, noted R29 had a Interview for Mental Statu indicated impaired cognition. Reporting and timely submed R58 was interviewed on 7 when asked the question, anyone else here abused verbal, physical or sexual "Yes" to surveyor. R58 stated nurse assistants (Naware of it as they were in time and R24 "has had a was asked, "Have you see being abused?" and R58 stated R58 overheard R24 "to shut up." The quarterly MDS dated scored a 15 of 15 on the Research and R54 of 15 on the R54 overheard R24 "To shut up."	transferred with a could have occurred a mbulation if R29 withly twisted his ankle. The injury could have a lift if R29 moved foot a standing plate during interview, R29 stated by foot." No witnesses at. The report read pairment prevented R29 storian. The initial report day later. The final and on 1/27/14, six days discore of 3 on the Brief is (BIMS) which on. The report read pairment prevented R29 storian. The initial report day later. The final and on 1/27/14, six days discore of 3 on the Brief is (BIMS) which on. The report read pairment prevented R29 storian. The initial report day later. The final and on 1/27/14, at 6:09 p.m. and "Has staff, a resident or you-this includes abuse?" R58 answered ated R24 had yelled at ant times. R58 also late with times. R58 also late dining room at the few talking's to." R58 and any resident here answered, "Yes", and 4 yell at other residents	21990				

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winnesc	ita Department of He	aith				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
	00557		B. WING		07/2	25/2014
		00001			0112	.5/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RENVII I	A HEALTH CENTER	205 SOUT	HEAST ELM	M AVENUE		
IVEINAIEE	A IILALIII OLIVILIX	RENVILLE	E, MN 56284	1		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	PRIAIE	DAIL
				,		
21990	Continued From pa	ge 40	21990			
	intact cognition.					
	intact cognition.					
	On 7/21/14, at 6:32	p.m. registered nurse (RN)-D				
		staff were aware of R24's				
		ered "yes" and stated the				
		A had been notified about the				
		staff "more than once." RN-D				
		at happens R24's behaviors				
	were charted.	• •				
	At 6:37 p.m. SS-A stated she was aware of R24's					
	yelling at R58, and	stated one vulnerable adult				
		ng R24 had been filed, but not				
		at R58. SS-A stated she had				
		R24 individually about the				
		had not put notes into the				
		SS-A stated she only had her				
		nd said "Now I wish I would				
		t." SS-A stated she was also				
		ed at other residents. SS-A				
		nentia, a "short fuse", and R24				
		e incidents. SS-A stated at the				
		onsidered the yelling incidents				
		abuse as R58 and R24 have				
		her. SS-A stated she had not				
		to the SA. SS-A stated the				
		ed to SA on 7/25/14, which				
	was four days later.					
	0: 7/00/44 -4.54	a ma CC A state of the course				
		p.m. SS-A stated the usual				
	•	to the staff or residents,				
		rst, talk to the administrator,				
		decision was made whether				
		e SA. SS-A stated either SS-A				
		would make the report. ministrator stated yes she was				
		ole Incidents should be				
		tely to the SA, and was also				
		reports needed to be filed				
		days of the incident. Report of				
		R58 was not reported				
	verbai abase iroiii i	100 was not reported				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00557	B. WING		07/2	5/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RENVILI	A HEALTH CENTER		HEAST ELN			
	T		E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21990	Continued From pa	ge 41	21990			
	immediately to the	SA regarding R24.				
	On 7/24/14, at 9:55 loudly "two times a and staff. We were and redirect her. NAR24 then usually go out later. On 7/25/14, at 7:56 talked last night (on expressed feeling usually states at last night (on expressed feeling usually states at people." SS-A stated R58 results the strap" if I yelled is R24's nature; R2 at people." SS-A alshave put in the recal abuse." SS-A stated the verbal between resident abuse. At 8:37 a.m. SS-A stated the verbal between resident abuse. At 8:37 a.m. SS-A stated the verbal between resident abuse. At 9:09 a.m. SS-A prom Office of Healt sent on 7/25/14, (co to Minnesota Depar saying she had filed regarding R24. Whereport, SS-A replied of the incident report the print button whe At 9:12 a.m. SS-A sconsidered verbal abeen focusing on verside would now, individed the state of the state of the would now, individed the state of the state	a.m. NA-H stated R24 yelled day, every day" at residents told to try and calm R24 down A-H stated after she yelled bes to her room and comes a.m. SS-A stated she had a 7/24/14) to R58, R58 had ancomfortable around R24. ported, "I would have gotten like R24 did. SS-A stated "that 4 has a gruff voice, and snaps so stated, "I wished I would ord [R58's] report of verbald, "I haven't really focused on residents," but rather staff to said she had talked to staff ors, and stated, "but now t is a different story." provided a copy of the e-mail th Facility Complaints (OHFC) onfirmation of incident report rement of Health (MDH), d an incident report last night en asked for the incident d she could not provide a copy rt as she had forgotten to push en submitting the report. Stated mental anguish was abuse, however, she had not erbal abuse. SS-A also stated icating the facility should tered care, focusing on how				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00557	B. WING		07/	25/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RENVIL	LA HEALTH CENTER		ΓHEAST ELM E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21990	scored a six on the had severely impair dated 2/14/14, by S vulnerable due to in the cognition impair completely express indicated R59 was a conversations if givinclude dementia. R59 on 6/23/14, repthe head during bin and witnessed R24 down on the table. long standing histor was not clear if any between R24 and F have staff watch for R59 when together. On 7/23/14, at 1:50 to surveyor she four the morning of 6/24 she had talked to the incident and the add should have submit submitted on 6/25/11 R23's incident reportation of transfer while received The investigation for transfer while received so found staff had the staff using the found staff using the found staff using the found staff was found staff had the staff using the found staff using the found staff had the staff using the found staff using the f	S, dated 5/1/14, indicated R59 BIMS which indicated R59 ed cognition. A Progress note S-A stated R59 was a paired cognition and due to ment, R59 had some difficulty ing thoughts/words. The MDS able comprehend most en time. R59 had diagnosis to corted R24 hit R59 on back of go. Staff members overheard yell and slam R24's hand The incident report identified a ry between R24 and R59 and it thing physical happened R59. Follow up plan was to a agitation between R24 and report. The social worker stated and out about the incident on read a distribution of the social worker stated and and a stated and the social worker stated are administrator about that ministrator had told her she ted a report. The report was	21990			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		00557	B. WING		07/	25/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RENVILI	LA HEALTH CENTER		HEAST ELNE, MN 56284	-		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21990	fall. Staff was disciptraining on facility puransfer. The report injuries. The completed days later. R23's Quarterly MD R23 had scored a sindicating moderate on the submitted was also aware involved filed within five where the safeguard of the safeguard for the s	olined and was given further rocedure for assisting R23 to indicated R23 received minor eted investigative report was a on 3/21/14, which was nine as dated 6/25/14, indicated core of eight on the BIMS, ely impaired cognition. p.m. the administrator stated that reportable incidents of immediately to the SA, and estigative reports needed to working days of the incident. In Policy dated as an 7/13, identified St. Francis of established safeguards to not (Abuse or Neglect) of any to in the facility. The policy uards would adhere to the equirements, whichever was mponents of the Abuse noder A. states Definitions of each Neglect: Definitions of each	21990			

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Minnesota Department of Health

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
		00557	B. WING		07/2	25/2014	
	PROVIDER OR SUPPLIER	205 SOUT	DRESS, CITY, S THEAST ELM E, MN 56284				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21990	or a suspicious injureporter) to a reside his/her supervisor in the appropriate faci. C. Each facility mabuse/neglect to Mimeans as soon as part 24 hours after discential the incide of receip on file with the incide D. The facility admediately. E. Following computition of the SUGGESTED MET The administrator, and incectors could ensure adequate training in allegations of misagensure investigation manner at the time	ry (this is a mandated ent in the facility must notify mmediately, who will report to lity staff. ust report any suspected DH immediately ('immediately' possible, but ought not exceed overy of the incident). Save to freport from MDH. Keep it	21990				
22000	Reporting - Maltrea Subd. 14. Abuse facility, except hom personal care atten establish and enfor prevention plan. The assessment of the environment, and it factors which may experience the substantial of the personal care and the substantial of the personal care and the substantial of the substan	prevention plans. (a) Each e health agencies and dant services providers, shall ce an ongoing written abuse he plan shall contain an physical plant, its s population identifying encourage or permit abuse, specific measures to be taken	22000			9/8/14	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00557	B. WING		07/2	5/2014
	PROVIDER OR SUPPLIER LA HEALTH CENTER	205 SOUT	DRESS, CITY, S THEAST ELM E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	to minimize the risk comply with any rule promulgated by the (b) Each facility, agency and person providers, shall dev prevention plan for residing there or reconstruction of the plan shall contract assessment of: (1) abuse by other indivulnerable adults; (2) other vulnerable adults; (3) other vulnerable adults. For the purpeterm "abuse" include (c) If the facility, and personal care a knows that the vuln violent crime or an atoward others, the inplan must detail the minimize the risk the reasonably be expensively and persons unsupervised. Under the plan must detail the minimize the risk the reasonably and persons unsupervised. Under a vulnerable adumisconduct or physical information from authority or through another facility, and	of abuse. The plan shall es governing the plan licensing agency. including a home health care al care attendant services elop an individual abuse each vulnerable adult ceiving services from them. ain an individualized the person's susceptibility to viduals, including other 2) the person's risk of abusing ults; and (3) statements of the to be taken to minimize the t person and other vulnerable poses of this paragraph, the	22000			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00557	B. WING		07/2	5/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RENVILL	A HEALTH CENTER		HEAST ELN E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 46	22000			
	by: Based on interview facility failed to ope prohibition policy, w	ent is not met as evidenced and document review, the rationalize the abuse hich had the potential to affect s (R29, R58, R59, R23).		Corrected by September 8th, 201	4	
	Findings Include:					
	7/13, identified St. Festablished safegua (Abuse or Neglect) our facility. The safe	ion Policy Revised/Amended Francis Health Services had ards to prohibit Maltreatment of any VA (vulnerable adult) in eguards would adhere to the equirements, whichever was a policy indicated:				
	under A. states Def and Neglect: Defini maltreatment. (Phy Verbal Abuse, Ment	e Abuse Prohibition Policy initions of Maltreatment/Abuse tions of potential sical Abuse, Sexual Abuse, tal Abuse, Neglect, Financial ent to resident abuse).				
	Revised/Amended Services will follow alleged maltreatme facility, to the appro by the most stringe state rules and stat A. The person ob a suspicious injury to a resident in the supervisor immedia appropriate facility s C. Each facility m abuse/neglect to M	serving or suspecting abuse or (this is a mandated reporter) facility must notify his/her ately, who will report to the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
		00557	B WING		07/0	5/00//
		00557	D. WING		07/2	5/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DENI/II I	A HEALTH CENTER	205 SOUT	HEAST ELM	I AVENUE		
KENVILI	LA HEALIH CENTER	RENVILLE	E, MN 56284	l e		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 47	22000			
	24 hours after disconthis notice of receip on file with the incidence of the continuous discontinuous discontinuous discontified of alleged a immediately. E. Following commutation within five (5) working submit a copy of the R29's the incident reviewed and identified foot/ankle, discontinuous d	overy of the incident). Save of report from MDH. Keep it				
	noted to c/o pain lo R29 again reported and left foot was sw was then periodical and elevated with refoot. The investigat non-ambulatory morestorative ambulat indicated R29 was and the injury could transfer or during a wrong and/or slight also indicated the in while in standing lift displaced from star procedure. Upon in "bumped into my for any incident. Th	eport indicated R29 was first cated in the knee on 1/16/14. I pain on 1/18/14, of left foot wollen at the time. The left foot ly checked over the weekend elief. Shoe was left off of left ive report identified R29 was lest of the time except for ion program. The report transferred with stand-up lift. I have occurred during a mbulation if R29 stepped ly twisted his ankle. The report nigury could have occurred tif R29 moved foot or foot was adding plate during transfer terview, R29 stated someone lot." No witnesses were noted to report read dementia and at prevented R29 from being				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
	00557	B. WING		07/	25/2014
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
RENVILLA HEALTH CENTER		THEAST ELM .E, MN 56284	AVENUE		
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
to the SA one day later report was submitted the incident occurred. On 7/23/14, at 2:18 p yes she was aware the should be submitted it was also aware investigated when asked the questigated and stated nurse assigned were aware of that as room at the time and to." R58 was asked "It here being abused" as and stated R58 overhing abused and stated R58 overhing RN-D answere social worker (SS)-A by different staff "mor stated when that happing charted. -At 6:37 p.m. SS-A star R24's yelling at R58, adult (VA) report regar	The initial report was made er. The final investigative on 1/27/14, six days after .m. the administrator stated nat reportable incidents immediately to the SA, and stigative reports needed to rking days of the incident. on 7/21/14, at 6:09 p.m. and stion "Has staff, a resident or used you-this includes xual abuse?" R58 rveyor. R58 stated R24 had up two different times. R58 sistants (NAs) and nurses at they were in the dining R24 "has had a few talking's Have you seen any resident and R58 answered "Yes", neard R24 yell at other "The report was called to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00557	B. WING		07/2	25/2014
	VIDER OR SUPPLIER	205 SOUT	DRESS, CITY, S FHEAST ELM E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
ov ha av straption from a later or a later o	vn paper notes, and ve documented it vare R24 has yellowed R24 had denoted after the end of the she had not come R24 as verbal ong history together that time had not an 7/23/14, at 1:51 occess was talking vestigate a little file a report to the administrator to 2:18 p.m. the acts as aware that report of verbal abundant of verbal abund	SS-A stated she only had her and said "now I wish I would t." SS-A stated she was also ed at other residents. SS-A mentia, a "short fuse", and R24 incidents. SS-A stated at the onsidered the yelling incidents abuse as R58 and R24 have her. SS-A stated she therefore submitted a report to the SA. p.m. SS-A stated the usual to the staff or residents, rst, talk to the administrator, he decision was made whether as SA. SS-A stated either SS-A would make the report. In diministrator stated yes she ortable Incidents should be tely to the SA, and was also reports needed to be filed days of the incident. The lise from R58 was not reported SA regarding R24.				
no vu co co ab co	te dated 2/14/14, Inerable due to congnition impairment impletely expressible to if given time inversations. R59 59 on 6/23/14, repead during bingo.	aired cognition. A Progress by SS-A stated R59 was ognition and due to the nt R59 had some difficulty ing thoughts/words, but was , comprehend most had a history of dementia. Ported R24 hit R59 on back of Staff members overheard and and slam R24's hand down on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		00557	B. WING		07/2	25/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RENVILI	A HEALTH CENTER		HEAST ELM E, MN 56284			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
22000	standing history bet not clear if anything R24 and R59. Follo watch for agitation I together. On 7/23/14, at 1:50 to surveyor she fou the morning of 6/24 she had talked to the incident and the adishould have submitt submitted on 6/25/1 - At 2:18 p.m. the awas aware that reposubmitted immediate aware Investigative within five working of the submitted on 6/25/1 aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within five working of the submitted immediate aware Investigative within the submitted immediate aware Investigative with	p.m. the social worker stated nd out about the incident on /14. The social worker stated administrator had told her she tted a report. The report was	22000			
	while transferring we chair (w/c) to exerciusing gait belt. R23 hitting the head on R23 received a minimvestigation found transfer while received as found staff had assisting R23 which fall. Staff was discipated in training on facility performance. The report injuries. The final in completed on 3/21/	rt stated R23 fell on 3/12/14, ith staff assistance from wheel ise equipment without staff lost balance and R23 fell arm rest of chair and door. or skin tear on left ear. The R23 lost balance during a ving assistance from staff. It I not used a gait belt while may have prevented R23's blined and was given further rocedure for assisting R23 to stated R23 received minor vestigative report was 14, which was nine days later. p.m. the social worker (SS)-A d in 2012 and the vulnerable				

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00557	B. WING		07/2	5/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RENVILLA HEALTH CENTER			HEAST ELN E, MN 56284			
040.15	CLIMMA DV CTA		-		N.I	0.45)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
22000	Continued From pa	ge 51	22000			
	adult (VA) policy was stated the usual proor residents, investi administrator, discumade whether to file staff will call admini it, and the administrator be made, and eit will make the report update the policy to administrator/SA, the administrator streport immediately to call the administrator streported late, staff administrator was not reported late, staff adminis	is already in place. SS-A cross was talking to the staff gate a little first, talk to the ass, and then the decision is a report. SS-A stated night strator and they will talk about rator will decide if a report was ther SS-A or the administrator and to report immediately to the investigate. At 2:18 p.m. ated staff were trained to if a suspicion of abuse, were ator immediately, and if any and if any and if any and if any and if the administrator stated if should documented why. The administrator stated if should documented why. The ate at a minimum. The ate at a minimum and a staff were redure yearly at a minimum. The administrator also verified the facility's current relied the facility's current relied to be submitted and investigation reports within five working dates of the atended to be submitted and investigation reports within five working dates of the atended to be could audit, and				
	regarding reporting implementing the pr	and training to all staff responsibilities and rocedures of the Abuse and Vulnerable adult(s).				

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Minnesota Department of Health STATE FORM

TIME PERIOD FOR CORRECTION: Fourteen

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PRINTED: 10/03/2014 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING _ 00557 07/25/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 205 SOUTHEAST ELM AVENUE **RENVILLA HEALTH CENTER** RENVILLE, MN 56284 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETE DATE (X4) ID PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 22000 Continued From page 52 22000 (14) days.

Minnesota Department of Health