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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: YUCN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00626

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245418**

2.STATE VENDOR OR MEDICAID NO.
(L2) **901743700**

3. NAME AND ADDRESS OF FACILITY
(L3) **BELGRADE NURSING HOME**
(L4) **103 SCHOOL STREET, PO BOX 340**
(L5) **BELGRADE, MN** (L6) **56312**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/21/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Carrie Euerle, HNFE NE II — 10/15/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 10/23/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/02/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/17/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245418
October 21, 2015

Mr. Philip Lord, Administrator
Belgrade Nursing Home
103 School Street, P.O. Box 340
Belgrade, Minnesota 56312-0340

Dear Mr. Lord:

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 21, 2015 the above facility is certified for or recommended for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 21, 2015

Mr. Philip Lord, Administrator
Belgrade Nursing Home
103 School Street, P.O. Box 340
Belgrade, Minnesota 56312-0340

RE: Project Number H5418011 & S5418025

Dear Mr. Lord:

On September 10, 2015, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 10, 2015. (42 CFR 488.417 (b))

Also, we notified you in our letter of September 10, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 10, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on July 10, 2015, that included an investigation of complaint number H5418011, and lack of verification of substantial compliance with the health deficiencies at the time of our September 10, 2015 notice. The most serious health deficiencies in your facility at the time of the standard survey were found 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 October 15, 2015, the Minnesota Department of Health; Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 10, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 21, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 10, 2015, as of September 21, 2015.

As a result of the PCR findings, this Department took the following action with regard to the Category 1 remedy:

• Mandatory State Monitoring effective September 16, 2015, discontinued effective September 21, 2015. (42 CFR 488.422)

Furthermore this Department recommends to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of September 10, 2015.

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 10, 2015, be rescinded effective September 21, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 10, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 10, 2015, is to be rescinded.

In our letter of September 10, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 10, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 21, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245418	A. Building B. Wing	8/21/2015

Name of Facility	Street Address, City, State, Zip Code
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0241 Reg. # 483.15(a) LSC	08/12/2015	ID Prefix F0309 Reg. # 483.25 LSC	08/11/2015	ID Prefix F0323 Reg. # 483.25(h) LSC	08/12/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	JS/KJ	09/11/2015	29249	08/21/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/10/2015

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245418	01 - MAIN BUILDING 01	9/8/2015

Name of Facility	Street Address, City, State, Zip Code
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 09/04/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/KJ	09/11/2015	34764	09/08/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 7/8/2015

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00626	A. Building B. Wing	10/15/2015

Name of Facility	Street Address, City, State, Zip Code
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **21805** Reg. # **MN St. Statute 144.651 Subd. 5** LSC	**09/21/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	JS/KJ	10/21/2015	31591	10/15/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/24/2015

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 10, 2015

Mr. Philip Lord, Administrator
Belgrade Nursing Home
103 School Street, P.O. Box 340
Belgrade, Minnesota 56312-0340

RE: Project Number S5418025

****This letter redacts and replaces the letter dated February 10, 2015. It corrects the state deficiency designation.****

Dear Mr. Lord:

On July 23, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 10, 2015. 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 August 21, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your Plan of Correction and on September 8, 2015, 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 10, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 4, 2015. Based on our visit, we have determined that your facility has achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on July 10, 2015.

However, the Office of Health Facility Complaints completed an abbreviated standard survey August 24, 2015. The investigation team identified the following deficiency(ies) as uncorrected:

F 0241 - Dignity and Respect of Individuality
2 1805 - Patients and Residents of Hc Fac. Bill of Rights

The most serious deficiencies in your facility were found to be - isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective September 16, 2015. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 10, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective October 10, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 10, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Belgrade Nursing Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective October 10, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you

cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

DEPARTMENT CONTACT

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

Sarah Grebenc, MSW, Supervisor,
Office of Health Facility Complaints
Health Regulation Division
85 East Seventh Place, Suite 220
P. O. BOX 64970
St Paul, MN 55164-0970
Office 651-201-4135 **General Info: 651-201-4201**
Toll Free: 1-800-369-7994 **Fax: 651-281-9796**

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Services that your provider agreement be terminated by January 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 10, 2015

Mr. Philip Lord, Administrator
Belgrade Nursing Home
103 School Street, P.O. Box 340
Belgrade, Minnesota 56312-0340

RE: Project Number S5418025

Dear Mr. Lord:

On July 23, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 10, 2015. 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 August 21, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your Plan of Correction and on September 8, 2015, 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 10, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 4, 2015. Based on our visit, we have determined that your facility has achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on July 10, 2015.

However, the Office of Health Facility Complaints completed an abbreviated standard survey August 24, 2015. The investigation team identified the following deficiency(ies) as uncorrected:

F 0241 - Dignity and Respect of Individuality
F 1805 - Patients and Residents of Hc Fac. Bill of Rights

The most serious deficiencies in your facility were found to be - isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective September 16, 2015. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 10, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective October 10, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 10, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Belgrade Nursing Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective October 10, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written

request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

DEPARTMENT CONTACT

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

Sarah Grebenc, MSW, Supervisor,
Office of Health Facility Complaints
Health Regulation Division
85 East Seventh Place, Suite 220
P. O. BOX 64970
St Paul, MN 55164-0970
Office 651-201-4135 **General Info: 651-201-4201**
Toll Free: 1-800-369-7994 **Fax: 651-281-9796**

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245418	A. Building B. Wing	10/15/2015

Name of Facility	Street Address, City, State, Zip Code
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0241 Reg. # 483.15(a) LSC	09/21/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	JS/KJ	10/21/2015	31591	10/15/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/24/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: YUCN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00626

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245418**

2.STATE VENDOR OR MEDICAID NO.
(L2) **901743700**

3. NAME AND ADDRESS OF FACILITY
(L3) **BELGRADE NURSING HOME**
(L4) **103 SCHOOL STREET, PO BOX 340**
(L5) **BELGRADE, MN** (L6) **56312**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/10/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **49** (L18)

13.Total Certified Beds **49** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Annette Truebenbach, HFE NE II 08/11/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 09/01/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/17/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 1970
July 23, 2015

Mr. Philip Lord, Administrator
Belgrade Nursing Home
103 School Street, P.O. Box 340
Belgrade, Minnesota 56312-0340

RE: Project Number S5418025

Dear Mr. Lord:

On July 10, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
Health Regulation Division
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 19, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 19, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 10, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the

specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED AUG 0 6 2015 MN Dept of Health St.Cloud	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure each residents' dignity was maintained while discussing private resident information during the supper meal for 1 of 1 resident (R11) during dining observation. Findings include: R11's admission record dated 6/17/15, included diagnosis of Alzheimer's disease and dementia. R11's admission Minimum Data Set (MDS) dated 6/24/15, indicated R11 was severely cognitively impaired, and required extensive assistance of one to two staff with all activities of daily living	F 241	**1. Immediate action(s) taken for the resident(s) found to have been affected include:** The CNAs and RNs involved were immediately in-serviced on the proper procedures for maintaining resident dignity during mealtimes. **2. Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all residents requiring feeding assistance at meal times have the potential to be affected.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Philip Lord — TITLE: Administrator — (X6) DATE: 8.4.2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 (ADL's) and supervision with set up for meals. During an observation on 7/7/15, at 6:31 p.m. R11 was eating in the dining room, with three other residents sitting at the table. Two staff members, nursing assistant (NA)-B and NA-C, were sitting at the table assisting the residents with their supper meal. NA-B stated, "I put [R11] in the bathroom and [R11] just sat there." At 6:36 p.m., registered nurse (RN)-B was standing by R11's table, and commented how well R11 was eating. NA-B indicated R11 was hungry, and stated R11, "Sat and sat on the toilet the whole time I was on break." During interview on 7/7/15, at 6:40 p.m. RN-B stated, "Yeah, we probably shouldn't be talking about toileting someone at the supper table. I had just commented that he was eating really well and [NA-B] said when [R11] is restless, he usually needs to be toileted." During interview on 7/7/15, at 6:49 p.m. NA-B verified her conversation with RN-B regarding toileting R11, while other residents were sitting at the table eating supper. NA-B stated the conversation should not have been had around other residents. During interview on 7/8/15, at 4:30 p.m. director of nursing (DON) stated she discussed with staff to not share personal information about residents in front of others, and stated, "We talk about that here frequently...It's a constant...Don't share too much information." A review of the facility policy titled Quality of Life-Dignity dated 8/11, staff are directed to treat residents with dignity and respect at all times and	F 241	**3. Actions taken/systems put into place to reduce the risk of future occurrence include:** CNAs and other facility personnel involved in providing feeding assistance to residents will be in-serviced on the proper procedures for assisting residents with meals to ensure resident dignity is maintained during mealtimes. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing Services (DNS), or designee, will conduct random observations of staff during mealtimes over the next three (3) months to ensure staff are promoting and maintaining resident dignity during mealtimes in accordance with our facility's practice guidelines and regulatory requirements. Observation reports and validation checklists will be reviewed by the Risk Management/Quality Assurance Committee until such time	

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	245418	A. BUILDING _____ B. WING _____	07/10/2015

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F 241	Continued From page 2 to maintain an environment in which confidential clinical information is protected, including, "Verbal staff-to-staff communication...shall be conducted outside the hearing range of residents and the public."	F 241	consistent substantial compliance has been achieved as determined by the committee.	8/12/15
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to adequately monitor and reassess pain to ensure effective pain management for 1 of 1 residents (R41) reviewed for pain. Findings include: R41's quarterly Minimum Data Set (MDS), dated 6/12/15, identified R41 was cognitively intact. R41's current pain assessment dated 6/12/15, indicated the resident had pain continuously throughout the day, had pain with movement of joints in the left shoulder and hips, and indicated the pain is almost constant. R41 described the pain as an achy pain which made sleeping difficult.	F 309	**1. Immediate action(s) taken for the resident(s) found to have been affected include:** RI# 41 was assessed for pain, appropriate interventions were implemented. **2. Identification of other residents having the potential to be affected was accomplished by:** The interdisciplinary team reviewed the MDS Section J for all residents identified as being at risk for pain. Pain assessments are complete and interventions currently in place are appropriate. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** All licensed nursing staff will been in-serviced on the facility's *Pain Management* policy and procedure.	

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F 309	Continued From page 3 R41's Care area assessment (CAA) dated 3/18/15, indicated the residents pain is severe and disturbs his sleep and adversely affects his mood. During interview on 7/08/2015, at 4:12 p.m. R41 stated he tells staff all the time he is in constant pain which is severe. R41 stated he does not feel he gets enough relief from the pain with the current medications. The resident stated staff will use a pain patch sometimes which can be helpful. R41's care plan dated 9/24/14, indicated "The resident has chronic pain r/t (related to) Disease process, [rheumatoid arthritis] and bilateral knee/hip pain, and left shoulder pain." Interventions were identified as anticipate the resident's need for pain relief, respond immediately to any complaints of pain, evaluate the effectiveness of pain interventions, review for compliance, alleviating symptoms, and dosing schedules. R41's pain assessment dated 6/12/15 indicated "[R41] had chronic generalized pain through out. He receives scheduled Morphine which is effective for a short period of time after given. In the look back period ...He rates his pain at moderate to severe, but rates numerically at 8-10..." R41's current physician orders for June 2015, indicated the resident had pain medication orders for Gel [biofreeze] every morning and at bedtime for left hip pain, and PRN (as needed) every 6 hours for left hip pain, with a start date of 2/19/15. Morphine Sulfate 100 mg/ 5 ML, 1 ML daily by mouth three times a day, and 1 ML every 6 hours	F 309	**4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing Services (DNS), or designee, will complete random pain assessment audits to ensure appropriate completion for six (6) consecutive weeks. Audits will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	8/11/15

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F 309	Continued From page 4 as needed for pain related to lower leg pain, with a start date of 6/18/14. Although the pain assessment indicated the resident was still having severe pain, and the Morphine was only effective for a short period of time, there was no indication there were any further pain medications attempted since 6/18/14, over a year ago. R41's Medication administration record (MAR) for May 2015, indicated the resident did not utilize the PRN Morphine, or the PRN biofreeze gel. The MAR for June 2015, indicated the resident utilized the PRN Morphine once on 6/14/15, and did not utilize the PRN biofreeze gel. During interview on 07/08/2015, at 2:54 p.m. licensed practical nurse (LPN)-A stated R41 complains of constant pain and rates his pain as moderate (6-10 on a 1-10 scale). During interview on 07/08/2015, at 2:55 p.m.Registered nurse (RN)-B stated R41's pain is always between a 6-10, and the resident takes scheduled morphine three times a day, and has as needed Morphine, however, this is not used. RN-B stated the resident also uses biofreeze as needed. During interview on 07/08/2015, at 3:00 p.m., the director of nursing stated R41's pain is considered controlled if he is able to do activities and does not cry out or show pain all of the time. A Nursing progress noted dated 5/16/15, indicated R41 told staff, "Well it just hurts all the time. None of the pain medication helps anyway. Morphine only works for about 15 minutes." The undated policy entitled Pain management	F 309		

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F 309	Continued From page 5 and assessment indicated, "If the resident's pain is not controlled by the current treatment regime, the physician should be notified."	F 309	**1. Immediate action(s) taken for the resident(s) found to have been affected include:** • The Director of Nursing Services met with the RNs. Safety and fall risk assessments were completed for Resident # 5. Appropriate revisions were made to the care plans to reflect all current safety interventions. • Personal equipment for RI# 5 and RI# 30 were removed and repaired. These items were then returned to the residents. **2. Identification of other residents having the potential to be affected was accomplished by:** • The nursing team reviewed the MDS Assessments for all residents who have been identified as having a potential risk for falls. Fall and safety risk assessments are complete and interventions currently in place are appropriate.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident safety equipment was correctly applied and/or maintained in good repair, for 2 of 2 residents (R5 and R30) who were observed with mobility equipment in need of repair or adjustment. The facility also failed to conduct a thorough investigation into the root-cause of a fall for 1 of 3 residents (R5) reviewed, who was identified as at risk for falls. Findings include: R5's Medication Review Report dated 5/22/15, identified diagnoses including Alzheimer's disease, macular degeneration, generalized pain and personal history of fall. R5's quarterly Minimum Data Set (MDS) dated 6/10/15, identified R5 had severely impaired cognition with delusions and was independent	F 323	JS per marlene 8/1/15	

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F 323	Continued From page 6 with most activities of daily living (ADLs). R5's care plan dated 6/17/15, identified R5 had a self-care performance deficit and mobility limitations related to weakness of the lower extremities, unsteadiness with ambulation,bilateral knee pain, and not knowing her limitations. R5 was independent with transfers and ambulation, with the use of her cane or walker and staff assistance as needed. The care plan also identified R5 was at a high risk for falls due to complaints of dizziness with standing, history of falls, poor vision, and frequent pacing. Interventions included encouragement to use her four-wheeled walker (4 WW) or cane with ambulation and ensure of a safe environment. The care plan directed information from her past falls be reviewed with attempts to determine the root cause, and if possible, remedying any potential causes. An Incident Note on 7/1/15, at 7:15 a.m. authored by licensed practical nurse (LPN)-G identified R5 was found sitting on the floor by her night stand. R5 stated she fell asleep while seated in her 4 WW and fell to the floor, hitting her head and received a small, red bump to her right temple. No other injuries and no pain were noted. The incident report indicated the call light had fallen to the floor and was located under R5's bed, R5 was noted as incontinent prior to the fall, which was not typical of her, but had occurred multiple times between that day and the day prior. LPN-G directed staff to monitor R5 for symptoms of a urinary tract infection (UTI) related to her incontinence, confusion, and this fall. At 12:01 p.m., registered nurse (RN)-G reviewed the fall, drawing a similar conclusion. RN-G directed staff to continue to observe for signs of a UTI and	F 323	• The facility has determined that all residents with personal equipment have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** • All Licensed Nursing staff will be in-serviced on the facility policy. All resident falls/accidents will be reviewed by the nursing team to ensure appropriate implementation of safety interventions including updating the plan of care . • All Licensed Nursing staff will be in-serviced on the need to inspect environmental items. All personal resident equipment will be checked with every RN fall assessment. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:**	

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F 323	Continued From page 7 update the physician as needed. She also initiated a three-day bowel and bladder assessment, "... in case change in continence is related to an increase in dementia so that a toileting schedule may be made up." During observation on 7/7/15, at 3:54 p.m. R5 was in her resident room seated on the bench of her 4 WW, rolling the walker backward and forward with her feet while she watched television. R5 motioned as though she was wanting to stand up from the seat, raising both her arms and shoulders to the handles of the walker and pushing down on the handles to lift herself up. However, she quickly brought her arms back down and reached back to the walker as she grasped the brake cables near the walker wheels, then moved her hands up the walker, trying to manipulate various components of the walker, as it appeared R5 was trying to activate the brakes of her 4 WW. When asked what she was trying to do, R5 confirmed she was looking for her brakes. After assisting her to locate and activate the brakes, the wheels of the 4 WW continued to move back and forth as R5 shifted her weight on the seat. At this time, LPN-H came to R5 room and assisted the resident with standing up from the 4 WW. LPN-H attempted to lock the bilateral handle brakes of the 4 WW and manually held the walker in place while providing extensive assistance for R5 to stand. As she stood, the wheels of the 4 WW again continued to move with the shifting of R5's weight from the bench seat. After R5 was standing safely and able to ambulate out of her room with her cane, LPN-H was asked whether the brakes of the 4 WW were in working order. LPN-H demonstrated the walker rolled back and forth with ease, although the the brakes were locked on 4 WW.	F 323	• The nursing management team will review each incident report upon occurrence to ensure appropriate interventions are implemented and updated plan of care is complete. The Director of Nursing Services (DNS), or designee, will complete random weekly chart audits for six (6) consecutive weeks and review all fall incident reports to ensure that appropriate interventions have been put in place to reduce the risk of resident falls/accidents and that care plans have been updated to reflect these interventions. • The Director of Nursing Services (DNS), or designee, will complete random audits for six (6) consecutive weeks and review all fall incident reports to ensure that all resident equipment was in working order and was not the root cause of an accident.	

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F 323	Continued From page 8 LPN-H stated she had not noticed this prior and would put in a work order for maintenance to fix the brakes. The only seating options observed in R5's portion of her shared resident room were her bed and the bench seat of her 4 WW, there was no chair in R5 room. Additional observations included the following: On 7/7/15, at 4:30 p.m. R5's 4 WW remained in her resident room, but the brakes had still not been repaired. With the brakes activated, the 4 WW moved back and forth with ease, but had not been removed from use. R5 was not in her room at the time of this observation. On 7/8/15, at 9:40 a.m. the 4 WW remained in R5's resident room, with the brakes still in disrepair. The walker had not been removed from use. R5 was not in her resident room at this time. During the environmental tour on 7/9/15, at 12:58 p.m. the director of maintenance (DM) denied any knowledge of R5's walker needing repair. The 4 WW remained next to the night stand in R5's room as it had been during all prior observations, and DM activated the walker brakes, he immediately noticed the wheels continued to move back and forth with ease and stated, "It needs to be adjusted." DM stated if staff had informed maintenance of this repair need, it would have been written in his work order request book, located at the nurse's station. DM stated all staff were responsible for identifying safety concerns and filling out a maintenance work order request to address these concerns when appropriate, and stated this request was not written in the book and no work order request had been completed for R5's 4 WW brakes.	F 323	Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	8/12/15

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F 323	Continued From page 9 During interview on 7/9/15, at 1:12 p.m. LPN-G stated R5 mostly used her cane for ambulation, but did use her 4 WW while in her resident room. LPN-G stated R5's cognition varied greatly from moment to moment. LPN-G stated she had seen R5 utilize the bench seat on the 4 WW as a chair in her room, but she denied having noticed the brakes were malfunctioning. LPN-G stated R5 recently fell from the seat of her 4 WW and she was the nurse on duty at the time of the fall and responded to the fall scene when called to assist by the nursing assistant (NA). LPN-G stated R5 was sitting on the floor of her resident room with the 4 WW behind her. LPN-G confirmed she did not evaluate the 4 WW at the time of the fall to determine whether it was in proper working order, however, she stated the RN was responsible for assessment after a fall. During interview on 7/9/15, at 12:40 p.m. the director of nursing (DON) confirmed ensuring safety devices were in proper working order was the responsibility of all employees. DON stated R5's post-fall assessment was the responsibility of RN-G who was on duty at the time of the fall. RN-G was not available for interview. Review of the facility's Repair Request forms from 5/28/15, through 7/9/15, lacked a work order request to address R5's 4 WW brakes. The facility's Fall Policy dated 2/19/13, directed an investigation of a fall was to be conducted by the RN after the incident was reported. The RN was to review the complete incident report, which was to include potential factors related to the fall in his/her assessment and correct any potential problems.	F 323		

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F 323	Continued From page 10 R30's Order Summary Report dated 6/25/15, identified diagnoses including senile dementia with delusional features, obesity, and weakness. R30's quarterly MDS dated 4/20/15, identified her cognition was severely impaired and required extensive assistance for most ADLs. R30's care plan dated 5/1/15, noted R30's physical mobility was limited and she was unable to ambulate due to weakness and dementia with confusion. R30 was identified as being at moderate risk for falls related to poor safety awareness, poor upper body balance, and poor communication abilities. The care plan identified R30 required extensive to total assist of one staff for locomotion, but could move herself independently at times. The care plan did not specifically address R30's wheelchair use, or it's safety features. During observation on 7/7/15, at approximately 5:15 p.m. R30 was brought to the main lobby area, with approximately ten other residents seated throughout the general area. R30 was seated in a specialized, Tilt-In-Space wheelchair (a wheelchair which allowed a resident to be rotated instead of reclined, rotating the seat and back in place). The unidentified staff tilted the wheelchair back, resulting in an angle of approximately 35 degrees between the back of the wheelchair and the floor. The staff left the area to assist other residents. The wheelchair was noted with rear anti-tip bars (bars that were fitted on a wheelchair to prevent the resident from tipping over, most commonly fitted to the back of the wheelchair to prevent tipping in a backwards direction.). However, the anti-tip bars were curved up toward the ceiling, rather than down	F 323		

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towards the floor to prevent the wheelchair from tipping backwards.

On 7/9/15, at 12:15 p.m. R30 was observed while eating lunch in the main dining room. The anti-tip bars on her wheelchair remained in the upward position.

During an environmental tour with the facility's DM on 7/9/15, at 12:58 p.m. R30 was seated in her wheelchair in the main lobby area, and the anti-tip bars remained in the upward position. DM stated R30's anti-tip bars on the wheelchair were not properly applied and they should be turned down, and not up as they were currently on the wheelchair. DM immediately approached R30, removed the anti-tip bars, and re-applied them so they were curved down. DM stated that R30's wheelchair came to the facility pre-assembled, so he was unsure as to why the bars were turned upward. DM stated all staff were responsible for identifying safety concerns and filling out a maintenance work order request to address these concerns, and DM stated there had been no maintenance work order request related to R30's anti-tip bars.

During interview on 7/9/15, at 12:40 p.m. DON was asked about the appropriate application of anti-tip bars on wheelchairs. The DON stated she was not familiar with what anti-tip bars for wheelchairs were, so she could not speak to the appropriate application of this safety device. However, she confirmed that ensuring safety devices were in proper working order was the responsibility of all employees.

Review of the facility's Repair Request forms from 5/28/15, through 7/9/15, lacked a work order

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F 323	Continued From page 12 request to address R30's anti-tip bars. The undated Ti LITE User Friendly Anti-Tips Owners Manual (a manufacturer of anti-tip bars for wheelchairs) directed, "In order to properly use your anti-tips, please follow the following rules:" 1. Your anti-tips should be between 1-1/2 [one and a half] inches to 2 [two] inches off the ground when they are locked in place in the 'down' position. 2. If your anti-tips are set too LOW, they may 'catch' on obstacles that you can expect to encounter in normal wheelchair use. If this happens, you may tip over and fall. 3. If your anti-tips are set too HIGH, their ability to prevent backward tip-over will be limited and they may not prevent a tip-over at all. 4. ALWAYS keep your anti-tips locked in place in the 'down' position unless: a. You have an attendant (but your attendant must rotate the anti-tips into the 'down' position whenever he or she leaves you unattended in your chair, even for a moment, or b. You have to climb or descend a curb or step or overcome an obstacle. Even if this is the case, only unlock the anti-tippers if you can safely climb or descend the curb or step or overcome the obstacle and make sure the anti-tippers are locked in the 'up' position. "If you ignore these Warnings, you may fall, tip over or lose control of the wheelchair and seriously injury yourself or others or damage the wheelchair."	F 323		

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

F5418023

PRINTED: 07/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/08/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	**103 SCHOOL STREET, PO BOX 340** **BELGRADE, MN 56312**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT 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 08, 2015. At the time of this survey, Building 01 of Belgrade Nursing Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care 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	K 000	OK 9-15-15 RECEIVED [redacted] 13 [redacted] MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 8-19-15

Exit: 7-10-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Philip Lord — TITLE: Administrator — (X6) DATE: 8.4.2015

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

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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Belgrade Nursing Home was constructed as follows: The original building was constructed in 1965, is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction; The 1968 addition is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction; The 1981 addition is one story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction; The 1987 addition is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction; The 1988 addition is one story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type V(111) construction. The 1988 building addition consists of seven (7) senior apartments. Because the 1988 addition was not separated from the nursing home by	K 000		

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K 000	Continued From page 2 2-hour construction, the senior apartments were surveyed as part of the nursing home. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which are monitored for automatic fire department notification. The facility has a licensed capacity of 49 beds and had a census of 37 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET, as evidenced by:	K 000		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Observations indicated that the automatic sprinkler system has not been maintained in accordance with NFPA 13 Standard for the Installation of Sprinkler System 1999 edition section 5-5.6. This deficient practice may allow a fire to grow uncontrolled which will negatively	K 056	**1. Immediate action(s) taken for the resident(s) found to have been affected include:** All items were removed that were within 18 inches of the sprinkler system which included items in rooms 119, 123, north bath area, and activity department. **2. Identification of other residents having the potential to be affected was accomplished by:** The facility determined that all resident rooms and storage areas have a potential to be affected.	

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K 056	Continued From page 3 impact all the residents, visitors and staff. Findings include: Observations during the facility tour onJuly 8, 2015, between 0800 am and 1130 am, revealed that storage in the following areas were within 18 inches of the sprinkler heads within the rooms; 1) Patient rooms 119 and 123. 2) North Bath area and Activities Department The Facilities Maintenance Director (DW) Verified these findings during the facility tour.	K 056	**3. Actions taken/systems put into place to reduce the risk of future occurrence include:** The facility has ordered steel wire material to be attached to the top shelf of each storage area to prevent items from being placed within 18" of the sprinkler system heads. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The Plant Operations Manager and/or designees will monitor storage areas to assure that items are not stored within 18" of the sprinkler system heads.	9/4/15

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	245418	A. BUILDING **02 - PT-E THERPY** B. WING _____	**07/08/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 08, 2015. At the time of this survey, Building 02 of Belgrade Nursing Home was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies Building 02 of Belgrade Nursing Home consists of the 2013 Physical Therapy addition. This addition is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which are monitored for automatic fire department notification. The facility has a licensed capacity of 49 beds and had a census of 37 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET, as evidenced by:	K 000		

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

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MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 1970
July 23, 2015

Mr. Philip Lord, Administrator
Belgrade Nursing Home
103 School Street, P.O. Box 340
Belgrade, Minnesota 56312-0340

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5418025

Dear Mr. Lord:

The above facility was surveyed on July 7, 2015 through July 10, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules 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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 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.

When all orders are corrected, the order form should be signed and returned to this office at 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,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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Minnesota Department of Health

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On July 7-10, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using the 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	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Marlene Groetsch RN DON

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2 000	Continued From page 1 Certification Program, 3333 West Division St, Suite 212, St Cloud, MN 56301. Minnesota Department of Health is documenting the State Licensing Correction Orders using the 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 which are in violation of the state statute after the statement, "This Rule 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.	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and	2 830		

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2 830	Continued From page 2 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to adequately monitor and reassess pain to ensure effective pain management for 1 of 1 residents (R41) reviewed for pain. Findings include: R41's quarterly Minimum Data Set (MDS), dated 6/12/15, identified R41 was cognitively intact. R41's current pain assessment dated 6/12/15, indicated the resident had pain continuously throughout the day, had pain with movement of joints in the left shoulder and hips, and indicated the pain is almost constant. R41 described the pain as an achy pain which made sleeping difficult. R41's Care area assessment (CAA) dated 3/18/15, indicated the residents pain is severe and disturbs his sleep and adversely affects his mood. During interview on 7/08/2015, at 4:12 p.m. R41 stated he tells staff all the time he is in constant pain which is severe. R41 stated he does not feel he gets enough relief from the pain with the current medications. The resident stated staff will	2 830	**1. Immediate action(s) taken for the resident(s) found to have been affected include:** RI# 41 was assessed for pain, appropriate interventions were implemented. **2. Identification of other residents having the potential to be affected was accomplished by:** The interdisciplinary team reviewed the MDS Section J for all residents identified as being at risk for pain. Pain assessments are complete and interventions currently in place are appropriate. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** All licensed nursing staff will been in-serviced on the facility's *Pain Management* policy and procedure.	

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2 830	Continued From page 3 use a pain patch sometimes which can be helpful. R41's care plan dated 9/24/14, indicated "The resident has chronic pain r/t (related to) Disease process, [rheumatoid arthritis] and bilateral knee/hip pain, and left shoulder pain." Interventions were identified as anticipate the resident's need for pain relief, respond immediately to any complaints of pain, evaluate the effectiveness of pain interventions, review for compliance, alleviating symptoms, and dosing schedules. R41's pain assessment dated 6/12/15 indicated "[R41] had chronic generalized pain through out. He receives scheduled Morphine which is effective for a short period of time after given. In the look back period ...He rates his pain at moderate to severe, but rates numerically at 8-10..." R41's current physician orders for June 2015, indicated the resident had pain medication orders for Gel [biofreeze] every morning and at bedtime for left hip pain, and PRN (as needed) every 6 hours for left hip pain, with a start date of 2/19/15. Morphine Sulfate 100 mg/ 5 ML, 1 ML daily by mouth three times a day, and 1 ML every 6 hours as needed for pain related to lower leg pain, with a start date of 6/18/14. Although the pain assessment indicated the resident was still having severe pain, and the Morphine was only effective for a short period of time, there was no indication there were any further pain medications attempted since 6/18/14, over a year ago. R41's Medication administration record (MAR) for May 2015, indicated the resident did not utilize the PRN Morphine, or the PRN biofreeze gel.	2 830	**4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing Services (DNS), or designee, will complete random pain assessment audits to ensure appropriate completion for six (6) consecutive weeks. Audits will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	8/11/15

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2 830	Continued From page 4 The MAR for June 2015, indicated the resident utilized the PRN Morphine once on 6/14/15, and did not utilize the PRN biofreeze gel. During interview on 07/08/2015, at 2:54 p.m. licensed practical nurse (LPN)-A stated R41 complains of constant pain and rates his pain as moderate (6-10 on a 1-10 scale). During interview on 07/08/2015, at 2:55 p.m.Registered nurse (RN)-B stated R41's pain is always between a 6-10, and the resident takes scheduled morphine three times a day, and has as needed Morphine, however, this is not used. RN-B stated the resident also uses biofreeze as needed. During interview on 07/08/2015, at 3:00 p.m., the director of nursing stated R41's pain is considered controlled if he is able to do activities and does not cry out or show pain all of the time. A Nursing progress noted dated 5/16/15, indicated R41 told staff, "Well it just hurts all the time. None of the pain medication helps anyway. Morphine only works for about 15 minutes." The undated policy entitled Pain management and assessment indicated, "If the resident's pain is not controlled by the current treatment regime, the physician should be notified." SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee, could review and revice policies and procedures related to pain assessments, monitoring and care, and could provide staff education related to pain management. The director of nursing or designee could develop an audit tool to ensure appropriate	2 830		

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2 830	Continued From page 5 care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure screening of active tuberculosis symptoms and tuberculosis testing (TB) was completed upon admission for 1 of 5 newly admitted residents (R40) reviewed for TB testing. In addition, the facility failed to ensure	21426	**1. Immediate action(s) taken for the resident(s) found to have been affected include:** Questionnaires for affected residents will be completed for residents that were affected. **2. Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all residents have the potential to be affected **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** Licensed staff involved in providing tuberculosis screens to residents will be in-serviced on the proper procedures to complete the questionnaire form. The tuberculosis and infection control plan will also be reviewed.	

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	00626	A. BUILDING: _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

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21426	Continued From page 6 the screening for active tuberculosis symptoms were dated when completed in 4 of 4 newly admitted residents (R5, R16, R21, R37) reviewed for baseline tuberculosis screening. Findings include: R40's Admission Nursing Data Collection form dated 5/1/15, , identified R40 was admitted on 5/1/15. The form indicated the TB screening section, was not completed. R5's Admission Nursing Data Collection form dated 3/4/15, identified R5 had been admitted on 5/1/15. The TB screening form was completed, however, there was no date or signature on the form to identify if it had been completed timely. R16's Admission Nursing Data Collection form dated 12/8/14, identified R16 had been admitted on 12/8/14. The TB screening form was completed, however, there was no date or signature on the form to identify if it had been completed timely. R21's Admission Nursing Data Collection form dated 11/24/14, identified R21 had been admitted on 11/24/14. The TB screening form was completed, however, there was no date or signature on the form to identify if it had been completed timely. R37's Admission Nursing Data Collection form dated 4/30/15, identified R37 had been admitted on 4/30/15. The TB screening form was completed, however, there was no date or signature on the form to identify if it had been completed timely. During interview on 7/8/15, at 10:40 a.m.	21426	**4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing Services (DNS), or designee, will conduct monthly audits of tuberculosis forms for all new admission for the next 3 months to ensure staff are completing and dating the questionnaire form in accordance with our facility's practice guidelines and regulatory requirements. Observation reports will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	8/11/15

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21426	Continued From page 7 registered nurse (RN)-A stated the tuberculin screening for R40 was not completed, and also verified the date and signature on R5, R16, R21, and R37's tuberculin risk assessment was not present, and stated she was unable to determine if the screening was completed timely without a date. The facilities Tuberculosis Infection Control Plan policy was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff responsible for education and documentation of resident TB status. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21426		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident safety equipment was correctly applied and/or maintained in good repair, for 2 of 2 residents (R5 and R30) who were observed with mobility equipment in need of repair or adjustment. The facility also failed to conduct a thorough investigation into the root-cause of a fall for 1 of 3	21665	**1. Immediate action(s) taken for the resident(s) found to have been affected include:** • The Director of Nursing Services met with the RNs. Safety and fall risk assessments were completed for Resident # _40___. Appropriate revisions were made to the care plans to reflect all current safety interventions. • Personal equipment for RI# 5 and RI# 30 were removed and repaired. These items were then returned to the residents.	

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21665	Continued From page 8 residents (R5) reviewed, who was identified as at risk for falls. Findings include: R5's Medication Review Report dated 5/22/15, identified diagnoses including Alzheimer's disease, macular degeneration, generalized pain and personal history of fall. R5's quarterly Minimum Data Set (MDS) dated 6/10/15, identified R5 had severely impaired cognition with delusions and was independent with most activities of daily living (ADLs). R5's care plan dated 6/17/15, identified R5 had a self-care performance deficit and mobility limitations related to weakness of the lower extremities, unsteadiness with ambulation,bilateral knee pain, and not knowing her limitations. R5 was independent with transfers and ambulation, with the use of her cane or walker and staff assistance as needed. The care plan also identified R5 was at a high risk for falls due to complaints of dizziness with standing, history of falls, poor vision, and frequent pacing. Interventions included encouragement to use her four-wheeled walker (4 WW) or cane with ambulation and ensure of a safe environment. The care plan directed information from her past falls be reviewed with attempts to determine the root cause, and if possible, remedying any potential causes. An Incident Note on 7/1/15, at 7:15 a.m. authored by licensed practical nurse (LPN)-G identified R5 was found sitting on the floor by her night stand. R5 stated she fell asleep while seated in her 4 WW and fell to the floor, hitting her head and received a small, red bump to her right temple.	21665	**2. Identification of other residents having the potential to be affected was accomplished by:** • The nursing team reviewed the MDS Assessments for all residents who have been identified as having a potential risk for falls. Fall and safety risk assessments are complete and interventions currently in place are appropriate. • The facility has determined that all residents with personal equipment have the potential to be affected. **3. Actions taken/systems put into place to reduce the risk of future occurrence include:** • All Licensed Nursing staff will be in-serviced on the facility policy. All resident falls/accidents will be reviewed by the nursing team to ensure appropriate implementation of safety interventions including updating the plan of care .	

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21665	Continued From page 9 No other injuries and no pain were noted. The incident report indicated the call light had fallen to the floor and was located under R5's bed, R5 was noted as incontinent prior to the fall, which was not typical of her, but had occurred multiple times between that day and the day prior. LPN-G directed staff to monitor R5 for symptoms of a urinary tract infection (UTI) related to her incontinence, confusion, and this fall. At 12:01 p.m., registered nurse (RN)-G reviewed the fall, drawing a similar conclusion. RN-G directed staff to continue to observe for signs of a UTI and update the physician as needed. She also initiated a three-day bowel and bladder assessment, "... in case change in continence is related to an increase in dementia so that a toileting schedule may be made up." During observation on 7/7/15, at 3:54 p.m. R5 was in her resident room seated on the bench of her 4 WW, rolling the walker backward and forward with her feet while she watched television. R5 motioned as though she was wanting to stand up from the seat, raising both her arms and shoulders to the handles of the walker and pushing down on the handles to lift herself up. However, she quickly brought her arms back down and reached back to the walker as she grasped the brake cables near the walker wheels, then moved her hands up the walker, trying to manipulate various components of the walker, as it appeared R5 was trying to activate the brakes of her 4 WW. When asked what she was trying to do, R5 confirmed she was looking for her brakes. After assisting her to locate and activate the brakes, the wheels of the 4 WW continued to move back and forth as R5 shifted her weight on the seat. At this time, LPN-H came to R5 room and assisted the resident with standing up from the 4 WW. LPN-H attempted to	21665	• All Licensed Nursing staff will be in-serviced on the need to inspect environmental items. All personal resident equipment will be checked with every RN fall assessment. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** • The nursing management team will review each incident report upon occurrence to ensure appropriate interventions are implemented and updated plan of care is complete. The Director of Nursing Services (DNS), or designee, will complete random weekly chart audits for six (6) consecutive weeks and review all fall incident reports to ensure that appropriate interventions have been put in place to reduce the risk of resident falls/accidents and that care plans have been updated to reflect these interventions.	

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21665	Continued From page 10 lock the bilateral handle brakes of the 4 WW and manually held the walker in place while providing extensive assistance for R5 to stand. As she stood, the wheels of the 4 WW again continued to move with the shifting of R5's weight from the bench seat. After R5 was standing safely and able to ambulate out of her room with her cane, LPN-H was asked whether the brakes of the 4 WW were in working order. LPN-H demonstrated the walker rolled back and forth with ease, although the the brakes were locked on 4 WW. LPN-H stated she had not noticed this prior and would put in a work order for maintenance to fix the brakes. The only seating options observed in R5's portion of her shared resident room were her bed and the bench seat of her 4 WW, there was no chair in R5 room. Additional observations included the following: On 7/7/15, at 4:30 p.m. R5's 4 WW remained in her resident room, but the brakes had still not been repaired. With the brakes activated, the 4 WW moved back and forth with ease, but had not been removed from use. R5 was not in her room at the time of this observation. On 7/8/15, at 9:40 a.m. the 4 WW remained in R5's resident room, with the brakes still in disrepair. The walker had not been removed from use. R5 was not in her resident room at this time. During the environmental tour on 7/9/15, at 12:58 p.m. the director of maintenance (DM) denied any knowledge of R5's walker needing repair. The 4 WW remained next to the night stand in R5's room as it had been during all prior observations, and DM activated the walker brakes, he immediately noticed the wheels continued to move back and forth with ease and stated, "It needs to be adjusted." DM stated if staff had	21665	• The Director of Nursing Services (DNS), or designee, will complete random audits for six (6) consecutive weeks and review all fall incident reports to ensure that all resident equipment was in working order and was not the root cause of an accident. Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	8/12/15

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21665	Continued From page 11 informed maintenance of this repair need, it would have been written in his work order request book, located at the nurse's station. DM stated all staff were responsible for identifying safety concerns and filling out a maintenance work order request to address these concerns when appropriate, and stated this request was not written in the book and no work order request had been completed for R5's 4 WW brakes. During interview on 7/9/15, at 1:12 p.m. LPN-G stated R5 mostly used her cane for ambulation, but did use her 4 WW while in her resident room. LPN-G stated R5's cognition varied greatly from moment to moment. LPN-G stated she had seen R5 utilize the bench seat on the 4 WW as a chair in her room, but she denied having noticed the brakes were malfunctioning. LPN-G stated R5 recently fell from the seat of her 4 WW and she was the nurse on duty at the time of the fall and responded to the fall scene when called to assist by the nursing assistant (NA). LPN-G stated R5 was sitting on the floor of her resident room with the 4 WW behind her. LPN-G confirmed she did not evaluate the 4 WW at the time of the fall to determine whether it was in proper working order, however, she stated the RN was responsible for assessment after a fall. During interview on 7/9/15, at 12:40 p.m. the director of nursing (DON) confirmed ensuring safety devices were in proper working order was the responsibility of all employees. DON stated R5's post-fall assessment was the responsibility of RN-G who was on duty at the time of the fall. RN-G was not available for interview. Review of the facility's Repair Request forms from 5/28/15, through 7/9/15, lacked a work order request to address R5's 4 WW brakes.	21665		

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21665	Continued From page 12 The facility's Fall Policy dated 2/19/13, directed an investigation of a fall was to be conducted by the RN after the incident was reported. The RN was to review the complete incident report, which was to include potential factors related to the fall in his/her assessment and correct any potential problems. R30's Order Summary Report dated 6/25/15, identified diagnoses including senile dementia with delusional features, obesity, and weakness. R30's quarterly MDS dated 4/20/15, identified her cognition was severely impaired and required extensive assistance for most ADLs. R30's care plan dated 5/1/15, noted R30's physical mobility was limited and she was unable to ambulate due to weakness and dementia with confusion. R30 was identified as being at moderate risk for falls related to poor safety awareness, poor upper body balance, and poor communication abilities. The care plan identified R30 required extensive to total assist of one staff for locomotion, but could move herself independently at times. The care plan did not specifically address R30's wheelchair use, or it's safety features. During observation on 7/7/15, at approximately 5:15 p.m. R30 was brought to the main lobby area, with approximately ten other residents seated throughout the general area. R30 was seated in a specialized, Tilt-In-Space wheelchair (a wheelchair which allowed a resident to be rotated instead of reclined, rotating the seat and back in place). The unidentified staff tilted the wheelchair back, resulting in an angle of approximately 35 degrees between the back of	21665		

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21665	Continued From page 13 the wheelchair and the floor. The staff left the area to assist other residents. The wheelchair was noted with rear anti-tip bars (bars that were fitted on a wheelchair to prevent the resident from tipping over, most commonly fitted to the back of the wheelchair to prevent tipping in a backwards direction.). However, the anti-tip bars were curved up toward the ceiling, rather than down towards the floor to prevent the wheelchair from tipping backwards. On 7/9/15, at 12:15 p.m. R30 was observed while eating lunch in the main dining room. The anti-tip bars on her wheelchair remained in the upward position. During an environmental tour with the facility's DM on 7/9/15, at 12:58 p.m. R30 was seated in her wheelchair in the main lobby area, and the anti-tip bars remained in the upward position. DM stated R30's anti-tip bars on the wheelchair were not properly applied and they should be turned down, and not up as they were currently on the wheelchair. DM immediately approached R30, removed the anti-tip bars, and re-applied them so they were curved down. DM stated that R30's wheelchair came to the facility pre-assembled, so he was unsure as to why the bars were turned upward. DM stated all staff were responsible for identifying safety concerns and filling out a maintenance work order request to address these concerns, and DM stated there had been no maintenance work order request related to R30's anti-tip bars. During interview on 7/9/15, at 12:40 p.m. DON was asked about the appropriate application of anti-tip bars on wheelchairs. The DON stated she was not familiar with what anti-tip bars for wheelchairs were, so she could not speak to the	21665		

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21665	Continued From page 14 appropriate application of this safety device. However, she confirmed that ensuring safety devices were in proper working order was the responsibility of all employees. Review of the facility's Repair Request forms from 5/28/15, through 7/9/15, lacked a work order request to address R30's anti-tip bars. The undated Ti LITE User Friendly Anti-Tips Owners Manual (a manufacturer of anti-tip bars for wheelchairs) directed, "In order to properly use your anti-tips, please follow the following rules:" 1. Your anti-tips should be between 1-1/2 [one and a half] inches to 2 [two] inches off the ground when they are locked in place in the 'down' position. 2. If your anti-tips are set too LOW, they may 'catch' on obstacles that you can expect to encounter in normal wheelchair use. If this happens, you may tip over and fall. 3. If your anti-tips are set too HIGH, their ability to prevent backward tip-over will be limited and they may not prevent a tip-over at all. 4. ALWAYS keep your anti-tips locked in place in the 'down' position unless: a. You have an attendant (but your attendant must rotate the anti-tips into the 'down' position whenever he or she leaves you unattended in your chair, even for a moment, or b. You have to climb or descend a curb or step or overcome an obstacle. Even if this is the case, only unlock the anti-tippers if you can safely climb or descend the curb or step or overcome the obstacle and make sure the anti-tippers are locked in the 'up' position. "If you ignore these Warnings, you may fall, tip	21665		

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21665	Continued From page 15 over or lose control of the wheelchair and seriously injury yourself or others or damage the wheelchair." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of ensuring mobility devices are working properly and/or assembled properly. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21665		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure each residents' dignity was maintained while discussing private resident information during the supper meal for 1 of 1 resident (R11) during dining observation. Findings include:	21805	**1. Immediate action(s) taken for the resident(s) found to have been affected include:** The CNAs and RNs involved were immediately in-serviced on the proper procedures for maintaining resident dignity during mealtimes. **2. Identification of other residents having the potential to be affected was accomplished by:** The facility has determined that all residents requiring feeding assistance at meal times have the potential to be affected.	

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21805	Continued From page 16 R11's admission record dated 6/17/15, included diagnosis of Alzheimer's disease and dementia. R11's admission Minimum Data Set (MDS) dated 6/24/15, indicated R11 was severely cognitively impaired, and required extensive assistance of one to two staff with all activities of daily living (ADL's) and supervision with set up for meals. During an observation on 7/7/15, at 6:31 p.m. R11 was eating in the dining room, with three other residents sitting at the table. Two staff members, nursing assistant (NA)-B and NA-C, were sitting at the table assisting the residents with their supper meal. NA-B stated, "I put [R11] in the bathroom and [R11] just sat there." At 6:36 p.m., registered nurse (RN)-B was standing by R11's table, and commented how well R11 was eating. NA-B indicated R11 was hungry, and stated R11, "Sat and sat on the toilet the whole time I was on break." During interview on 7/7/15, at 6:40 p.m. RN-B stated, "Yeah, we probably shouldn't be talking about toileting someone at the supper table. I had just commented that he was eating really well and [NA-B] said when [R11] is restless, he usually needs to be toileted." During interview on 7/7/15, at 6:49 p.m. NA-B verified her conversation with RN-B regarding toileting R11, while other residents were sitting at the table eating supper. NA-B stated the conversation should not have been had around other residents. During interview on 7/8/15, at 4:30 p.m. director of nursing (DON) stated she discussed with staff to not share personal information about residents in front of others, and stated, "We talk about that	21805	**3. Actions taken/systems put into place to reduce the risk of future occurrence include:** CNAs and other facility personnel involved in providing feeding assistance to residents will be in-serviced on the proper procedures for assisting residents with meals to ensure resident dignity is maintained during mealtimes. **4. How the corrective action(s) will be monitored to ensure the practice will not recur:** The Director of Nursing Services (DNS), or designee, will conduct random observations of staff during mealtimes over the next three (3) months to ensure staff are promoting and maintaining resident dignity during mealtimes in accordance with our facility's practice guidelines and regulatory requirements.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00626	A. BUILDING: _____ B. WING _____	07/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 17 here frequently...It's a constant...Don't share too much information." A review of the facility policy titled Quality of Life-Dignity dated 8/11, staff are directed to treat residents with dignity and respect at all times and to maintain an environment in which confidential clinical information is protected, including, "Verbal staff-to-staff communication...shall be conducted outside the hearing range of residents and the public." SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to the provision of dignified care and services. Employees could be re-educated on these policies. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21805	Observation reports and validation checklists will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee.	8/12/15