CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: YUCN

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

	PART	I - TO BE COM	THE STAT	ATE SURVEY AGENCY Facility ID: 00626						
MEDICARE/MEDICAID PROVIDER NO. (L1) 245418 2.STATE VENDOR OR MEDICAID NO. (L2) 901743700).	3. NAME AND ADI (L3) BELGRADE (L4) 103 SCHOOL (L5) BELGRADE	NURSING HON	ME	(L6)	56312	4. TYPE OF ACTION: 1. Initial 3. Termination 5. Validation	7 (L8) 2. Recertification 4. CHOW 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWN (L9)		7. PROVIDER/SUF	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other omplaint		
6. DATE OF SURVEY 08/21/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDING 09/30	DATE: (L35)		
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	49 (L18) 49 (L17)	10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With Program Requirements Compliance Based On:1. Acceptable POC B. Not in Compliance with Program Requirements and/or Applied Waivers:			And/Or Approved Waivers Of The Following Requirements: 2. Technical Personnel 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 8. Patient Room Size 5. Life Safety Code 9. Beds/Room * Code: A* (L12)					
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF	19 SNF	ICF	IID		15. FACILITY MI		(L15)			
(L37) (L38)	(L39)	(L42)	(L43)							
16. STATE SURVEY AGENCY REMARKS	S (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):							
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY API	PROVAL	Date:		
<u>Carrie Euerle,</u>	HNFE NE I	<u>I</u> :	10/15/2015	(L19)	(224)					
	PART II - TO	BE COMPLETE	D BY HCFA R	EGIONAI	OFFICE OR S	SINGLE STAT	E AGENCY			
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Particle 2. Facility is not Eligible	cipate (L21)		IPLIANCE WITH O	CIVIL	2. (al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA	A-1513)		
22. ORIGINAL DATE OF PARTICIPATION 02/01/1987	23. LTC AGREEMI BEGINNING I		4. LTC AGREEMI ENDING DAT		26. TERMINAT VOLUNTARY 01-Merger, Closu	00	INVOLUNT	L30) <u>FARY</u> eet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction	n W/ Reimbursemer	nt 06-Fail to M	eet Agreement		
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVI A. Suspension of B. Rescind Suspension	of Admissions:	(L44) (L45)		03-Risk of Involui 04-Other Reason i		OTHER 07-Provider 00-Active	Status Change		
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS					
		03001								
	(L28)			(L31)						
31. RO RECEIPT OF CMS-1539		. DETERMINATION (09/17/2015	OF APPROVAL DA		Posted 11/	02/2015 Co.				
	(L32)			(L33)	DETERMINA	ATION APPRO	VAL			



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



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

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245418	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/21/2015
Name	of Facility		Street Address, City, State, Zip Code	
BELGRADE NURSING HOME			103 SCHOOL STREET, PO BOX 3 BELGRADE, MN 56312	40

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	(Y:	5) Date	(Y4) Item	C	(5) Date	(Y4)	Item	(Y5)	Date
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix	F0241	08/12/2015	ID Prefix	F0309	08/11/2015		ID Prefix	F0323	08/12/2015
0	483.15(a)	_		483.25				483.25(h)	
LSC		_	LSC				LSC		
		Onwesties			0				O a serve attians
		Correction			Completed				Correction Completed
ID Prefix		Completed	ID Prefix		Completed		ID Prefix		
Reg. #			Reg. #						
LSC		_					LSC		
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix		Completed
Reg. #			Reg. #				Reg. #		
		_							
		_				+-			 _
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		_	ID Prefix				ID Prefix		
Reg. #			Reg. #				Reg. #		
LSC		_	LSC		_		LSC		
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		_	ID Prefix				ID Prefix		
Reg. #			Reg. #				Reg. #		
LSC		_	LSC				LSC		
Reviewed By	Reviewed	і Ву	Date:	Signature of Su	rveyor:			Dat	te:
State Agency	,	JS/KJ	09/11/20	15	2	9249)	08	8/21/2015
Reviewed By	Reviewed	I Ву	Date:	Signature of Su	rveyor:			Dat	te:
CMS RO									
Followup to	Survey Completed on:				ny Uncorrected			-	
	7/10/2015			Uncorre	cted Deficiencie	s (CMS	3-2567) Sent	to the Facility?	ES NO

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245418	(Y2) Multiple Construction A. Building B. Wing 01 - MAI	N BUILDING 01	(Y3) Date of Revisit 9/8/2015
Name of Facility		Street Address, City, State, Zip Code	
BELGRADE NURSING HOME		103 SCHOOL STREET, PO BOX 3 BELGRADE, MN 56312	40

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)	Da	te	(Y4)	Item	(Y5) [Date
		(Correction				Corre	ection					Correction
			Completed				Com	pleted					Completed
ID Prefix			09/04/2015		ID Prefix		_			ID Prefix			_
Reg. #	NFPA 101				Reg. #		_			Reg. #			_
LSC	K0056				LSC					LSC			_
		(Correction				Corre	ection					Correction
ID Danfin			Completed		ID Danfiss		Com	pleted		ID Deefis			Completed
ID Prefix							_						_
Reg. #					Reg. #		-			Reg. #			_
LSC					LSC				<u> </u>	LSC			_
			O ti				0						0
			Correction					ection					Correction
ID Prefix			Completed		ID Prefix		Com	pleted		ID Prefix			Completed
Reg. #							_			Reg. #			_
LSC													_
				_			-		+-				
			Correction				Corre	ection					Correction
			Completed					pleted					Completed
ID Prefix			·		ID Prefix		_			ID Prefix			_
Reg. #					Reg. #					Reg. #			
LSC					LSC		-			LSC			- -
		(Correction				Corre	ection					Correction
ID Drofiv			Completed		ID Drofiv			pleted		ID Drofiv			Completed
							-						_
Reg. #					Reg. # LSC		-			Reg. #			_
LSC							-		<u> </u>	LSC			
Reviewed By	Review	ved B	у	Da	te:	Signature of Surve	yor:					Date:	
State Agency	,	C	SS/KJ	09	/11/2015			34764				09/0	08/2015
Reviewed By	Review	ved B	у	Da	te:	Signature of Surve	yor:					Date:	
CMS RO													
Followup to	Survey Completed on:	:				Check for any	Unco	rrected D	eficie	encies. Was	a Summarv of	<u> </u>	
	7/8/2015					-					to the Facility?	YES	NO

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).

(4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
		Correction			Correction					Correction
ID D . C		Completed	10.0.6		Completed		ID D . C			Completed
ID Prefix		09/21/2015			-		ID Prefix			
-	MN St. Statute 144.651 Sub		Reg. #		-		Reg. #			_
LSC			LSC		-		LSC			
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix			ID Prefix		-		ID Prefix			_
Reg. #			Reg. #		-		Reg. #			_
LSC			LSC		-		LSC			
		Correction			Correction					Correction
ID Desfer		Completed	ID Doofee		Completed		ID Desfer			Completed
ID Prefix	-				-		ID Prefix			_
Reg. #			Reg. #		=		Reg. #			_
							LSC			_
		Correction			Correction					Correction
ID D . C		Completed	10.0.6		Completed		10.0 %			Completed
					-		ID Prefix			_
Reg. #			Reg. #				Reg. #			_
LSC			LSC		-		LSC			_
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix			ID Prefix		-		ID Prefix			
Reg. #			Reg. #		-		Reg. #			_
LSC			LSC		•					
	,								I	
Reviewed By	Reviewed E	Ву	Date:	Signature of Surve	yor:				Date:	
State Agency	, JS	S/KJ	10/21/2015		315	91			10	0/15/2015
Reviewed By	Reviewed E	Ву	Date:	Signature of Surve	yor:				Date:	
CMS RO										
Followup to	Survey Completed on:						ncies. Was a S			
	8/24/2015			Uncorrecte	d Deficiencie	s (CMS-	2567) Sent to tl	he Facility?	YES	NO
STATE FORM	1: REVISIT REPORT (5.	/99)		Page 1 of 1			E	vent ID: 1	YF912	



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



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

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245418	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/15/2015
Name of Facility		Street Address, City, State, Zip Code	
BELGRADE NURSING HOME		103 SCHOOL STREET, PO BOX 3 BELGRADE, MN 56312	40

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	(Yŧ	5) [Date
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix	F0241	09/21/2015	ID Prefix		-		ID Prefix _			_
0	483.15(a)	_	Reg. #		-		Reg. #			_
LSC			LSC		-		LSC _			_
		0			0					O a man a ti a sa
		Correction Completed			Correction Completed					Correction Completed
ID Prefix			ID Prefix				ID Prefix			Completed
Reg. #			Reg. #							_
LSC		- -			-		-			- -
		0 "			0 "	T-				0 "
		Correction			Correction					Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #		_	Reg. #		_		Reg. #			_
		_			-					-
			-		-					
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		_	ID Prefix		-		ID Prefix _			_
Reg. #		_	Reg. #		-		Reg. #			_
LSC		=	LSC		-	<u> </u>	LSC _			=
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		_	ID Prefix		-		ID Prefix _			_
Reg. #		_	Reg. #		_		Reg. #			_
LSC			LSC		-		LSC _			
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:			D	ate:	
State Agency	,	JS/KJ	10/21/201	.5	(3159	1		10/	15/2015
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:			D	ate:	
CMS RO										
Followup to	Survey Completed on:			Check for any				-		
	8/24/2015			Uncorrecte	d Deficiencies	(CMS-	2567) Sent to	the Facility?	YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: YUCN

 ${\bf MEDICARE/MEDICAID\ CERTIFICATION\ AND\ TRANSMITTAL}$

	PART	I - TO BE COM	PLETED BY	THE STAT	E SURVEY AGENCY	Fac	eility ID: 00626
MEDICARE/MEDICAID PROVIDER NO. (L1) 245418	0.	3. NAME AND ADD (L3) BELGRADE				4. TYPE OF ACTION:	2 (L8)
2.STATE VENDOR OR MEDICAID NO.		(L4) 103 SCHOO	L STREET, PO	BOX 340		Initial Termination	2. Recertification 4. CHOW
(L2) 901743700		(L5) BELGRADE	, MN		(L6) 56312	5. Validation 7. On-Site Visit	6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF OWN	NERSHIP	7. PROVIDER/SUI	PPLIER CATEGOR	RY	<u>02</u> (L7)	8. Full Survey After Com	
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	o. Tun our vey Arter Com	, in the second
6. DATE OF SURVEY 07/10 /	/2015 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	EIGCAL VEAR ENDING D	ATE: (1.25)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING D	ATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS	k:			
From (a):		A. In Complian	nce With		And/Or Approved Waivers Of T	The Following Requirements:	_
To (b):		Program Re	equirements		2. Technical Personnel	6. Scope of Service	s Limit
10 (0):		Compliance	Based On:		3. 24 Hour RN	7. Medical Director	
12.Total Facility Beds	49 (L18)	1. A	acceptable POC		4. 7-Day RN (Rural SN		e
		D W	# 14 B		5. Life Safety Code	9. Beds/Room	
13. Total Certified Beds	49 (L17)	X B. Not in Com	pliance with Progra ents and/or Applied	m Waivers:	* Code: B *	(L12)	
14. LTC CERTIFIED BED BREAKDOWN		ı			15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
49					.,,,,		
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL	.ATION DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL	Date:
Annette Truebenba	ch, HFE NE	II	08/11/2015	(L19)	Kate JohnsTon, P	rogram Specialist	09/01/2015 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA R	` ′	OFFICE OR SINGLE STA	ATE AGENCY	(E20)
19. DETERMINATION OF ELIGIBILITY			IPLIANCE WITH	CIVIL		ncial Solvency (HCFA-2572)	
1. Facility is Eligible to Part	icipate	RIGI	HTS ACT:		Ownership/Contro Both of the Above	ol Interest Disclosure Stmt (HCFA-	1513)
2. Facility is not Eligible							
	(L21)						
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	24. LTC AGREEM	ENT	26. TERMINATION ACTION:	(L3	(0)
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	ΓΕ	VOLUNTARY	00 INVOLUNTA	RY
02/01/1987					01-Merger, Closure	05-Fail to Mee	t Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursen	nent 06-Fail to Mee	t Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVI	E CANCTIONS	(225)		03-Risk of Involuntary Termination	OTHER	
23. LIC EXTENSION DATE.	A. Suspension of				04-Other Reason for Withdrawal	<u>OTHER</u> 07-Provider St	atus Change
	A. Suspension of	of Admissions.	(L44)			00-Active	atus Change
(L27)	B. Rescind Sus	pension Date:	(LTT)			********	
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION (OF APPROVAL DA	ATE	Posted 09/17/2015 (Co.	
	(L32)			(L33)	DETERMINATION APPRO	OVAL	



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;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

Belgrade Nursing Home July 23, 2015 Page 2

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

Belgrade Nursing Home July 23, 2015 Page 4

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

Belgrade Nursing Home July 23, 2015 Page 5

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

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		245418	B. WING_		07	//10/2015		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 07	710/2015		
BELGRAD	E NURSING HOME			103 SCHOOL STREET, PO BOX 340				
				BELGRADE, MN 56312				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE		
F 000	as your allegation of o	correction (POC) will serve compliance upon the	F 00	RECEIVED				
	Department's accepta	nce. Your signature at the e of the CMS-2567 form will		AUG 0 6 2015		-		
F 241 SS=D	revisit of your facility in validate that substanting regulations has been a your verification. 483.15(a) DIGNITY AI INDIVIDUALITY The facility must proming an environment and in an environment and in an environment of his of the facility failed dignity was maintained are sident information duration of 1 resident (R11) duration of	al compliance with the attained in accordance with ND RESPECT OF ote care for residents in a ronment that maintains or not's dignity and respect in	F 24	MN Dept of Health St.Cloud	ken to de: ed ed on y ential I that ing ave			

LABORATORY DRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

Selministrator

4.7015

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.

	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245418	B. WING		07/10/2015	
	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312	07/10/2015	
(X4) IC PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	. ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 24	(ADL's) and supervision During an observation R11 was eating in the other residents sitting members, nursing ass were sitting at the tabl with their supper meal in the bathroom and [F p.m., registered nurse R11's table, and commeating. NA-B indicated	on with set up for meals. on 7/7/15, at 6:31 p.m. dining room, with three at the table. Two staff sistant (NA)-B and NA-C, e assisting the residents . NA-B stated, "I put [R11] R11] just sat there." At 6:36 (RN)-B was standing by nented how well R11 was	F 24	3. Actions taken/systems into place to reduce the r future occurrence include CNAs and other facility personnel involved in provide feeding assistance to reside will be in-serviced on the procedures for assisting residents with meals to ensertident dignity is maintained during mealtimes.	ding ents oper	
	stated, "Yeah, we probabout toileting someon just commented that he [NA-B] said when [R11 needs to be toileted." During interview on 7/7 verified her conversation toileting R11, while oth the table eating supper conversation should not other residents. During interview on 7/8 of nursing (DON) state to not share personal ir in front of others, and shere frequentlyIt's a comuch information." A review of the facility purified by the said of the	of have been had around of 15, at 4:30 p.m. director d she discussed with staff information about residents stated, "We talk about that constantDon't share too		4. How the corrective acti will be monitored to ensure the practice will not recure. The Director of Nursing Ser (DNS), or designee, will contain an observations of standaring mealtimes over the number of three (3) months to ensure a sare promoting and maintain resident dignity during meal in accordance with our facili practice guidelines and regulatory requirements. Observation reports and validation checklists will be reviewed by the Risk Management/Quality Assuration committee until such time	vices duct f ext staff ng times ty's	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII	(X3) DATE SUR	(X3) DATE SURVEY COMPLETED		
		245418	B. WING		07/10/2	2015	
	PROVIDER OR SUPPLIER DE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312	0771072	.013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) MPLETION DATE	
F 241 F 309 SS=D	to maintain an enviror clinical information is staff-to-staff communi outside the hearing rapublic."	ment in which confidential protected, including, "Verbal cationshall be conducted nge of residents and the RE/SERVICES FOR	F 24	compliance has been achievas determined by the comm 1. Immediate action(s) tak	en	12/15	
	provide the necessary or maintain the highes mental, and psychoso accordance with the cand plan of care. This REQUIREMENT			Rl# 41 was assessed for pa appropriate interventions we implemented. 2. Identification of other residents having the potento be affected was accomplished by:	ere		
	review the facility failed reassess pain to ensur management for 1 of 1 for pain. Findings include: R41's quarterly Minimu	residents (R41) reviewed m Data Set (MDS), dated		The interdisciplinary team reviewed the MDS Section 3 all residents identified as be at risk for pain. Pain assessments are complete a interventions currently in pla are appropriate.	ing and		
	indicated the resident has throughout the day, has joints in the left shoulded	essment dated 6/12/15, nad pain continuously d pain with movement of er and hips, and indicated tant. R41 described the		3. Actions taken/systems prints place to reduce the rist future occurrence include: All licensed nursing staff will been in-serviced on the facil Pain Management policy and procedure.	ity's		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245418	B. WING		07/10/2015
NAME OF PROVIDER OR SUPPLIER BELGRADE NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312	1 07/10/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 309	R41's Care area asse 3/18/15, indicated the		F 309	4. How the corrective action(s) will be monitore ensure the practice will no recur:	d to ot
ŀ	stated he tells staff all pain which is severe. he gets enough relief current medications. use a pain patch some helpful. R41's care plan dated resident has chronic p process, [rheumatoid a knee/hip pain, and left Interventions were ide resident's need for pai immediately to any conthe effectiveness of pa	The resident stated staff will etimes which can be 9/24/14, indicated "The ain r/t (related to) Disease arthritis] and bilateral shoulder pain." ntified as anticipate the		The Director of Nursing Ser (DNS), or designee, will complete random pain assessment audits to ensur appropriate completion for sconsecutive weeks. Audits will be reviewed by the Risk Management/Quality Assurance Committee until stime consistent substantial compliance has been achievas determined by the comm	e six (6) ne such ved
	"[R41] had chronic ger He receives scheduled	riod of time after given. In He rates his pain at			
	indicated the resident I for Gel [biofreeze] ever for left hip pain, and Pf hours for left hip pain, w Morphine Sulfate 100 r	n orders for June 2015, nad pain medication orders ry morning and at bedtime RN (as needed) every 6 with a start date of 2/19/15. ng/ 5 ML, 1 ML daily by ry, and 1 ML every 6 hours			

PRINTED: 07/23/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245418 B. WING 07/10/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET, PO BOX 340 **BELGRADE NURSING HOME** BELGRADE, MN 56312 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) F 309 Continued From page 4 F 309 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.

The undated policy entitled Pain management

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."

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245418	B. WING_		07/10)/2015	
	PROVIDER OR SUPPLIER DE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309 F 323 SS=D	and assessment indice is not controlled by the the physician should be 483.25(h) FREE OF A HAZARDS/SUPERVIST The facility must ensure environment remains as is possible; and each	ated, "If the resident's pain e current treatment regime, be notified." CCIDENT SION/DEVICES re that the resident as free of accident hazards	F 3	1. Immediate action(for the resident(s) fo	eund to nclude: sing RNs. sessments esident # evisions e plans to		
	by: Based on observation review, the facility faile equipment was correct maintained in good repand R30) who were observation and requipment in need of a facility also failed to convestigation into the residual of the resi	pair, for 2 of 2 residents (R5 served with mobility epair or adjustment. The	8 milis	 Personal equipment and RI# 30 were remore repaired. These items returned to the resident. 2. Identification of other residents having the to be affected was accomplished by: 	ved and were then its.		
	identified diagnoses in disease, macular dege and personal history of R5's quarterly Minimur 6/10/15, identified R5 h	neration, generalized pain fall. n Data Set (MDS) dated		The nursing team re the MDS Assessments residents who have be identified as having a p risk for falls. Fall and s assessments are comp interventions currently	for all en potential pafety risk plete and		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		245418	B. WING_			07	/10/2015	
	NAME OF PROVIDER OR SUPPLIER BELGRADE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312			110/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E VTE	(X5) COMPLETION DATE	
·	with most activities of R5's care plan dated of self-care performance limitations related to w extremities, unsteadin ambulation, bilateral kr her limitations. R5 wa transfers and ambulati cane or walker and sta The care plan also ide for falls due to compla standing, history of fall pacing. Interventions use her four-wheeled w ambulation and ensure The care plan directed falls be reviewed with root cause, and if poss potential causes. An Incident Note on 7/ by licensed practical newas found sitting on th R5 stated she fell asled WW and fell to the floor received a small, red b No other injuries and no incident report indicate the floor and was locat noted as incontinent pr not typical of her, but h between that day and to directed staff to monito urinary tract infection (t incontinence, confusion p.m., registered nurse	daily living (ADLs). 6/17/15, identified R5 had a deficit and mobility reakness of the lower less with lee pain, and not knowing s independent with ion, with the use of her aff assistance as needed intified R5 was at a high risk ints of dizziness with les, poor vision, and frequent included encouragement to walker (4 WW) or cane with les of a safe environment. Information from her past lattempts to determine the sible, remedying any 1/15, at 7:15 a.m. authored lurse (LPN)-G identified R5 les floor by her night stand. Les while seated in her 4 les, hitting her head and lump to her right temple. In the call light had fallen to led under R5's bed, R5 was light or to the fall, which was lad occurred multiple times les day prior. LPN-G r R5 for symptoms of a JTI) related to her land, and this fall. At 12:01 (RN)-G reviewed the fall, lusion. RN-G directed staff	F	323	 The facility has determine that all residents with person equipment have the potential be affected. 3. Actions taken/systems printo place to reduce the rist future occurrence include: All Licensed Nursing staff be in-serviced on the facility policy. All resident falls/accidents we reviewed by the nursing teamensure appropriate implementation of safety interventions including update the plan of care. All Licensed Nursing staff be in-serviced on the need to inspect environmental items. All personal resident equipmental personal resident equipmental assessment. 4. How the corrective action will be monitored to ensure the practice will not recur:	nal all to but k of will be not on to will on to hent N		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245418	B. WING		•		7/10/2015	
	PROVIDER OR SUPPLIER DE NURSING HOME			10	TREET ADDRESS, CITY, STATE, ZIP CODE 03 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312		7710/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE	
	update the physician initiated a three-day b assessment, " in carelated to an increase toileting schedule may. During observation on was in her resident rother 4 WW, rolling the forward with her feet witelevision. R5 motions wanting to stand up froher arms and shoulde walker and pushing do herself up. However, arms back down and rias she grasped the briwheels, then moved hittying to manipulate walker, as it appeared the brakes of her 4 WW was trying to do, R5 co for her brakes. After a activate the brakes. After a activate the brakes, the continued to move back her weight on the seat to R5 room and assiste standing up from the 4 lock the bilateral handl manually held the walk extensive assistance for stood, the wheels of the to move with the shifting bench seat. After R5 with able to ambulate out of the WW were in working of the walker rolled back.	as needed. She also owel and bladder se change in continence is in dementia so that a v be made up." 7/7/15, at 3:54 p.m. R5 om seated on the bench of walker backward and while she watched ed as though she was om the seat, raising both rest to the handles of the own on the handles to lift she quickly brought her eached back to the walker er hands up the walker, arious components of the R5 was trying to activate W. When asked what she onfirmed she was looking ssisting her to locate and e wheels of the 4 WW and forth as R5 shifted. At this time, LPN-H came ed the resident with WW. LPN-H attempted to be brakes of the 4 WW and ter in place while providing or R5 to stand. As she e 4 WW again continued go of R5's weight from the was standing safely and if her room with her cane, ther the brakes of the 4 rder. LPN-H demonstrated	F	323	 The nursing management team will review each incider report upon occurrence to ensure appropriate intervenare implemented and update plan of care is complete. The Director of Nursing Services (DNS), or designee, will complete random weekly chaudits for six (6) consecutive weeks and review all fall increports to ensure that appropriate interventions habeen put in place to reduce risk of resident falls/accident and that care plans have being updated to reflect these interventions. The Director of Nursing Services (DNS), or designeed complete random audits for second that all resident equipment was in working or and was not the root cause of accident. 	ent tions ed e art e ident ve the ss en		

	ENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONST A. BUILDING				(X3) DATE		
		245418	B. WING_			07/40/2045	
NAME OF PROVIDER OR SUPPLIER BELGRADE NURSING HOME				10	REET ADDRESS, CITY, STATE, ZIP CODE 33 SCHOOL STREET, PO BOX 340 ELGRADE, MN 56312	1 0/	7/10/2015
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
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.		F3		Audited records will be reviet by the Risk Management/Quassurance Committee until time consistent substantial compliance has been achievas determined by the comm	uality such /ed	8/12/15
	On 7/7/15, at 4:30 p.m her resident room, but been repaired. With the WW moved back and to been removed from us at the time of this obseron 7/8/15, at 9:40 a.m R5's resident room, with disrepair. The walker I	the 4 WW remained in the brakes still in					0,12,10
	p.m. the director of mai knowledge of R5's wall WW remained next to t room as it had been du and DM activated the w immediately noticed the move back and forth wi needs to be adjusted." informed maintenance would have been writte book, located at the nui all staff were responsib concerns and filling out order request to address appropriate, and stated	ring all prior observations, valker brakes, he wheels continued to the ease and stated, "It DM stated if staff had of this repair need, it in his work order request ree's station. DM stated le for identifying safety a maintenance work s these concerns when this request was not no work order request had					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245418	B. WING			07/10/2015	
NAME OF PROVIDER OR SUPPLIER BELGRADE NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	During interview on 7/stated R5 mostly used but did use her 4 WW LPN-G stated R5's comoment to moment. R5 utilize the bench sin her room, but she did brakes were malfunctive recently fell from the swas the nurse on duty responded to the fall siby the nursing assistating on the floothe 4 WW behind her not evaluate the 4 WW	19/15, at 1:12 p.m. LPN-G If her cane for ambulation, If while in her resident room. If while in her resident room. If you have a chair If you hav	F 32	23			
	however, she stated the assessment after a fall During interview on 7/5 director of nursing (DC safety devices were in the responsibility of all R5's post-fall assessment RN-G who was on the RN-G was not available.	ne RN was responsible for I. 9/15, at 12:40 p.m. the DN) confirmed ensuring proper working order was employees. DON stated lent was the responsibility luty at the time of the fall. le for interview.					
	from 5/28/15, through request to address R5 The facility's Fall Policy an investigation of a fathe RN after the incide was to review the compast to include potentia	Repair Request forms 7/9/15, lacked a work order s 4 WW brakes. y dated 2/19/13, directed II was to be conducted by nt was reported. The RN plete incident report, which al factors related to the fall and correct any potential					

PRINTED: 07/23/2015 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION					(X3) DATE SURVEY			
	•	ISELVIII IS WIGHT HOWBER.	A. BUILDING					COMPLETED		
245418			B. WING					7/10/2015		
NAME OF F	PROVIDER OR SUPPLIER			ı	STREET ADDRESS, CITY, STATE, ZIP			710/2015		
BELGRADE NURSING HOME				ı	103 SCHOOL STREET, PO BOX 34 BELGRADE, MN 56312	0				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BI THE APPROPRIA	E TE	(X5) COMPLETION DATE		
F 323	Continued From page	. 10	_	000						
1 020		y Report dated 6/25/15,	F	323						
	identified diagnoses in	ncluding senile dementia es, obesity, and weakness.								
	Will Goldoloria leature	es, obesity, and weakness.								
		dated 4/20/15, identified her y impaired and required for most ADLs.								
	to ambulate due to we confusion. R30 was it moderate risk for falls awareness, poor upper communication abilitie R30 required extensive for locomotion, but coundependently at times	limited and she was unable akness and dementia with dentified as being at related to poor safety body balance, and poor s. The care plan identified e to total assist of one staff								
	5:15 p.m. R30 was broarea, with approximate seated throughout the seated in a specialized (a wheelchair which all rotated instead of reclii back in place). The unwheelchair back, result approximately 35 degrethe wheelchair and the area to assist other reswas noted with rear an fitted on a wheelchair to tipping over, most comthe wheelchair to prevedirection.). However, ti	general area. R30 was I, Tilt-In-Space wheelchair lowed a resident to be ned, rotating the seat and identified staff tilted the ting in an angle of lees between the back of floor. The staff left the lidents. The wheelchair ti-tip bars (bars that were o prevent the resident from monly fitted to the back of ent tipping in a backwards								

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA. IDENTIFICATION NUMBER:	(X2) MULTIF	(X3) DATE SURVEY COMPLETED	-			
		245418	B. WING		07/10/2015			
NAME OF PROVIDER OR SUPPLIER BELGRADE NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312	1 07710/2013			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 323	- Commission Compa	ge 11 prevent the wheelchair from	F 32	23				
	eating lunch in the	p.m. R30 was observed while main dining room. The anti-tip hair remained in the upward						
	DM on 7/9/15, at 12 her wheelchair in the anti-tip bars remainstated R30's anti-tip not properly applied down, and not up as wheelchair. DM impremoved the anti-tip they were curved downeelchair came to he was unsure as to upward. DM stated identifying safety comaintenance work concerns, and DM stated	tental tour with the facility's 1:58 p.m. R30 was seated in e main lobby area, and the ed in the upward position. DM bars on the wheelchair were and they should be turned at they were currently on the mediately approached R30, bars, and re-applied them so own. DM stated that R30's the facility pre-assembled, so why the bars were turned all staff were responsible for necerns and filling out a order request to address these stated there had been no order request related to R30's						
	was asked about the anti-tip bars on whe she was not familiar wheelchairs were, s appropriate applicat However, she confir devices were in propresponsibility of all e	• •						
	Review of the facility	's Repair Request forms				1		

from 5/28/15, through 7/9/15, lacked a work order

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

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 A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245418	B. WING_			07/1	0/2045	
· .	ROVIDER OR SUPPLIER DE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312		07/10/2015		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	SE COMPLETION		
	request to address R3 The undated Ti LITE to Owners Manual (a may for wheelchairs) direct use your anti-tips, plearules:" 1. Your anti-tips shou and a half] inches to 2 when they are locked position. 2. If your anti-tips are 'catch' on obstacles the encounter in normal whappens, you may tip 3. If your anti-tips are to prevent backward tip they may not prevent at 4. ALWAYS keep your the 'down' position unlear you have an atmust rotate the anti-tip whenever he or she leary your chair, even for a rocase, only unlock the aclimb or descend the cothe obstacle and make ocked in the 'up' position.	Joer Friendly Anti-Tips anufacturer of anti-tip bars and, "In order to properly ase follow the following as following as following as too LOW, they may at you can expect to the following as too LOW, they may at you can expect to the following as too HIGH, their ability poover and fall. The following as too the following as too the following as to the following as you unattended in moment, or mother than the following as	F 3					
	over or lose control of t	he wheelchair and f or others or damage the						

PRINTED: 07/23/2015 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245418 07/08/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET, PO BOX 340 **BELGRADE NURSING HOME** BELGRADE, MN 56312 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5)**PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) K 000 **INITIAL COMMENTS** K 000 **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 DEPT, OF PUBLIC 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 LABORATORY, DID CTORE OR PROVIDER/SUPPLIED REF SENTATURE'S SIGNATURE

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

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

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL' A. BUILDI		(X3) DAT	(X3) DATE SURVEY COMPLETED		
	245418	B. WING			1 0	07/08/2015	
NAME OF PROVIDER OR SUPPLIER BELGRADE NURSING HOME			103	REET ADDRESS, CITY, STATE, ZIP CODE SCHOOL STREET, PO BOX 340 LGRADE, MN 56312		110012010	
PREFIX (EACH DEFICIENCE	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
DEFICIENCY MUST FOLLOWING INFOR 1. A description of what to correct the deficient 2. The actual, or proposed in the proposed i	RECTION FOR EACH INCLUDE ALL OF THE RMATION: nat has been, or will be, done ncy. cosed, completion date. itle of the person ction and monitoring to ce of the deficiency. de Nursing Home was s: was constructed in 1965, is as no basement, is fully fire and was determined to be of tion; one-story in height, has no sprinkler protected, and of Type II(111) construction; one story in height, has no sprinkler protected and was ype V(111) construction; one-story in height, has no sprinkler protected and was ype V(111) construction; one story in height, has no sprinkler protected, and of Type II(111) construction; one-story in height, has no sprinkler protected, and one story in height, has no sprinkler protected, and	K	000				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/23/2015 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245418 07/08/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET, PO BOX 340 **BELGRADE NURSING HOME** BELGRADE, MN 56312 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) K 000 Continued From page 2 K 000 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 056 NFPA 101 LIFE SAFETY CODE STANDARD 1. Immediate action(s) taken SS=F for the resident(s) found to If there is an automatic sprinkler system, it is have been affected include: installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to All items were removed that provide complete coverage for all portions of the building. The system is properly maintained in were within 18 inches of the accordance with NFPA 25, Standard for the sprinkler system which included Inspection, Testing, and Maintenance of items in rooms 119, 123, north Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water bath area, and activity supply for the system. Required sprinkler department. systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. Identification of other residents having the potential to be affected was accomplished by: This STANDARD is not met as evidenced by: Observations indicated that the automatic sprinkler system has not been maintained in The facility determined that all accordance with NFPA 13 Standard for the resident rooms and storage Installation of Sprinkler System 1999 edition areas have a potential to be section 5-5.6. This deficient practice may allow a fire to grow uncontrolled which will negatively affected.

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

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

		MEDICAID SERVICES			OWR M	O. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245418	B. WING		07	/08/2015
	PROVIDER OR SUPPLIER DE NURSING HOME		1	STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDEFICIENCY)	D BE	(X5) COMPLETION DATE
K 056	impact all the resident Findings include: Observations during the 2015, between 0800 at that storage in the folloinches of the sprinkler 1) Patient rooms 119 at 2) North Bath area and	ts, visitors and staff. the facility tour onJuly 8, am and 1130 am, revealed owing areas were within 18 theads within the rooms; and 123. d Activities Department ance Director (DW) Verified	K 056	3. Actions taken/syster into place to reduce the future occurrence inclu The facility has ordered s wire material to be attach the top shelf of each stora area to prevent items from placed within 18" of the sysystem heads. 4. How the corrective active will be monitored to ensithe practice will not recurrence. The Plant Operations Marand/or designees will monstorage areas to assure the items are not stored within the sprinkler system heads.	risk of de: teel ed to age being orinkler tion(s) ure ur: ager itor at 18" of	9/4/15

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

F5418023

Printed: 07/20/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 02 - PT-E THERPY

(X3) DATE SURVEY COMPLETED

245418

B. WING.

07/08/2015

NAME OF PROVIDER OR SUPPLIER

BELGRADE NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE

103 SCHOOL STREET. PO BOX 340 BELGRADE, MN 56312

	DE NOROMO NOME	BELGRADE,	MN	56312	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL F OR LSC IDENTIFYING INFORMATION)		FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	К	000		
	FIRE SAFETY A Life Safety Code Survey was conducted Minnesota Department of Public Safety, Fire Marshal Division, on July 08, 2015. Itime of this survey, Building 02 of Belgra Nursing Home was found to be in substant compliance with the requirements for pain Medicare/Medicaid at 42 CFR, Subpated 3.70(a), Life Safety from Fire, and the edition of National Fire Protection Associated.	State At the ade antial articipation art	2		
	(NFPA) Standard 101, Life Safety Code Chapter 18 New Health Care Occupance Building 02 of Belgrade Nursing Home of the 2013 Physical Therapy addition. This one-story in height, has no basement fire sprinkler protected, and was determ of Type V(111) construction. The facility has a fire alarm system with	(LSC), ies consists of is addition is fully ined to be smoke			
	detection in the corridors and spaces op corridors, which are monitored for auton department notification. The facility has licensed capacity of 49 beds and had a 37 at time of the survey. The requirement at 42 CFR Subpart 483	natic fire a census of		· ·	
	MET, as evidenced by:	((a)			
	RY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESE	THE SHAPE OF THE S		TITLE	(X6) DATE

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

(X6) DATE

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



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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.

Belgrade Nursing Home July 23, 2015 Page 2

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 Johns Ton, Program Specialist Licensing and Certification Program

Health Regulation Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

PRINTED: 07/23/2015 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00626	B. WING		07/10/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
BELGRA	DE NURSING HOME		OLSTREET, E. MN 56312	PO BOX 340		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID .	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE IATE	COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTENT	10N*****				,
	NH LICENSING CO	RRECTION ORDER				
	In accordance with Mir	nesota Statute, section n order has been issued				
	pursuant to a survey.	f, upon reinspection, it is				
	found that the deficient	y or deficiencies cited				
	nerein are not correcte	d, a fine for each violation		•		
-	with a schedule of fines the Minnesota Departm	promulgated by rule of	C			
	When a rule contains so comply with any of the lack of compliance. La- re-inspection with any in result in the assessmer	pliance with all provided at the tag umber indicated below everal items, failure to tems will be considered				
	You may request a hear that may result from nor	ing on any assessments n-compliance with these rritten request is made to 5 days of receipt of a r non-compliance.				
t t	he following correction corrections are complete nake a copy of these or original to the Minnesota	ed the above provider and orders are issued. When ed, please sign and date.		Minnesota Department of Health is documenting the State Licensing Correction Orders using the federal software. Tag numbers have been assigned to Minnesota state statutes/rule for nursing homes. The assigned tag number appears in the far left column	es	a 1

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 00626 07/10/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET, PO BOX 340 **BELGRADE NURSING HOME** BELGRADE, MN 56312 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 2 000 Continued From page 1 2 000 Certification Program, 3333 West Division St. entitled "ID Prefix Tag." The state Suite 212, St Cloud, MN 56301. statute/rule number and the corresponding text of the state statute/rule out of Minnesota Department of Health is documenting compliance is listed in the "Summary Statement of Deficiencies" column and the State Licensing Correction Orders using the federal software. Tag numbers have been replaces the "To Comply" portion of the assigned to Minnesota state statutes/rules for correction order. This column also nursing homes. The assigned tag number includes the findings which are in violation appears in the far left column entitled "ID Prefix of the state statute after the statement. "This Rule is not met as evidenced by." Tag." The state statute/rule number and the corresponding text of the state statute/rule out of Following the surveyors findings are the Suggested Method of Correction and the compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Time Period for Correction. Comply" portion of the correction order. This column also includes the findings which are in PLEASE DISREGARD THE HEADING OF violation of the state statute after the statement, THE FOURTH COLUMN WHICH "This Rule is not met as evidenced by." Following STATES, "PROVIDER'S PLAN OF the surveyors findings are the Suggested Method **CORRECTION." THIS APPLIES TO** of Correction and the Time Period for Correction. FEDERAL DEFICIENCIES ONLY. THIS WILLAPPEAR ON EACH PAGE. PLEASE DISREGARD THE HEADING OF THE THERE IS NO REQUIREMENT TO FOURTH COLUMN WHICH STATES. "PROVIDER'S PLAN OF CORRECTION." THIS SUBMIT A PLAN OF CORRECTION FOR APPLIES TO FEDERAL DEFICIENCIES ONLY. **VIOLATIONS OF MINNESOTA STATE** THIS WILL APPEAR ON EACH PAGE. STATUTES/RULES. 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 2 830 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

Willingso	ta Department of Healt	11			
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		00626	B. WING	<u> </u>	07/10/2015
					1 07/10/2015
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, ST		
BELGRAI	DE NURSING HOME		OOL STREET,	PO BOX 340	
		BELGRA	DE, MN 56312		
(X4) ID		ATEMENT OF DEFICIENCIES	· ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	1	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
			1/10	DEFICIENCY)	UAIL SILE
2 830	Continued From page	2	2 220		
2 000	Continued From page	: 2	2 830	1 Immediate action(a) 4	
l '	4658.0405. A nursing	home resident must be out		1. Immediate action(s) to	aken
	of bed as much as po	ssible unless there is a		for the resident(s) found	l to
		attending physician that the		have been affected inclu	ıde:
	resident must remain			DI# 44	
	prefers to remain in be	ed.		RI# 41 was assessed for I	pain,
				appropriate interventions	were
				implemented.	
	This MN Peguirement	is not met as evidenced		2. Identification of other	
	by:	is not met as evidenced		residents having the pot	
		, interview, and document		to be effected the pot	entiai
	review the facility faile	d to adequately monitor and		to be affected was	
	reassess pain to ensu			accomplished by:	1
-		1 residents (R41) reviewed		The interdisciplinary team	4
	for pain.				
				reviewed the MDS Section	
	Findings include:			all residents identified as b	peing
				at risk for pain. Pain	
	R41's quarterly Minim	um Data Set (MDS), dated		assessments are complete	and
	6/12/15, identified R41	I was cognitively intact.		interventions currently in p	
	D44la accessor a atalana				iace
	R41's current pain ass	sessment dated 6/12/15,		are appropriate.	
	indicated the resident	nad pain continuously ad pain with movement of		2 Antinum 4 1 4	
		ler and hips, and indicated		3. Actions taken/systems	put
1		stant. R41 described the		into place to reduce the I	risk of
	pain as an achy pain v			future occurrence includ	
	difficult.	The triade sleeping			
				All licensed nursing staff w	
	R41's Care area asses	ssment (CAA) dated		been in-serviced on the fac	cility's
	3/18/15, indicated the	residents pain is severe	1	Pain Management policy a	nd
		and adversely affects his		procedure.	114
	mood.	•		procedure.	
	During interview on 7/0	08/2015, at 4:12 p.m. R41			
1		the time he is in constant			
		R41 stated he does not feel			
	he gets enough relief f	rom the pain with the			
1	current medications	ine regident stated staff will	1		

Minne	sota Department of Healt	h			TORWATTROVED	
	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00626	B. WING		07/40/004	
NAME O	F PROVIDER OR SUPPLIER			ATE ZID CODE	07/10/2015	+
10 1112 0	. THOUSEN ON OUT LIEN		DDRESS, CITY, ST			
BELGF	ADE NURSING HOME		OOL STREET, 1 DE, MN 56312	PO BOX 340		
(X4) IE PREFI TAG	((EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE	
2 8	use a pain patch some helpful. R41's care plan dated resident has chronic process, [rheumatoid knee/hip pain, and left Interventions were idea resident's need for pain mediately to any content of the effectiveness of process compliance, alleviations schedules. R41's pain assessmee "[R41] had chronic general Hereceives schedule effective for a short pent the look back period moderate to severe, beneral medicated the resident for Gel [biofreeze] even for left hip pain, and Phours for left hip pain, Morphine Sulfate 100 mouth three times a das needed for pain relia start date of 6/18/14 assessment indicated	etimes which can be 1 9/24/14, indicated "The pain r/t (related to) Disease arthritis] and bilateral to shoulder pain." Intertified as anticipate the in relief, respond implaints of pain, evaluate ain interventions, review for graymptoms, and dosing interventions, and dosing interventions and dosing interventions and dosing interventions. In the rates his pain at ut rates numerically at in orders for June 2015, had pain medication orders by morning and at bedtime RN (as needed) every 6 with a start date of 2/19/15. In mg/ 5 ML, 1 ML daily by ay, and 1 ML every 6 hours ated to lower leg pain, with although the pain the resident was still	2 830		rvices re six (6) the such 8/11/15	
	effective for a short per indication there were a attempted since 6/18/18/18/18/18/18/18/18/18/18/18/18/18/	inistration record (MAR) for le resident did not utilize				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 00626 07/10/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET. PO BOX 340 **BELGRADE NURSING HOME** BELGRADE, MN 56312 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 2 830 Continued From page 4 2 830 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

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 00626 07/10/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET, PO BOX 340 **BELGRADE NURSING HOME** BELGRADE, MN 56312 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) 2 830 Continued From page 5 2 830 care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 1. Immediate action(s) taken 21426 MN St. Statute 144A.04 Subd. 3 Tuberculosis 21426 for the resident(s) found to **Prevention And Control** have been affected include: (a) A nursing home provider must establish and Questionnaires for affected maintain a comprehensive tuberculosis infection control program according to the most residents will be completed for current tuberculosis infection control guidelines residents that were affected. issued by the United States Centers for Disease Control and Prevention (CDC), Division of 2. Identification of other Tuberculosis Elimination, as published in CDC's residents having the potential Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis to be affected was infection control plan that covers all paid and accomplished by: unpaid employees, contractors, students, residents, and volunteers. The Department of The facility has determined that Health shall provide technical assistance all residents have the potential to regarding implementation of the guidelines. be affected (b) Written compliance with this subdivision must be maintained by the nursing home. 3. Actions taken/systems put into place to reduce the risk of future occurrence include: Licensed staff involved in providing tuberculosis screens This MN Requirement is not met as evidenced to residents will be in-serviced by: Based on interview and document review, the on the proper procedures to facility failed to ensure screening of active complete the questionnaire form. tuberculosis symptoms and tuberculosis testing The tuberculosis and infection (TB) was completed upon admission for 1 of 5 control plan will also be newly admitted residents (R40) reviewed for TB testing. In addition, the facility failed to ensure reviewed.

	ta Department of Healt	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			PLETED
		00626	B. WING		07	/10/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		•
BELGRAI	DE NURSING HOME		OOL STREET,			
			DE, MN 56312			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
21426	Continued From page	6	21426			
	were dated when con	ve tuberculosis symptoms npleted in 4 of 4 newly 5, R16, R21, R37) reviewed sis screening.		4. How the corrective act will be monitored to ensu	ıre	
	dated 5/1/15, identification, was not compared to the compared	ng Data Collection form and R5 had been admitted on hing form was completed, o date or signature on the d been completed timely. Ing Data Collection form and R16 had been admitted becreening form was there was no date or to identify if it had been Ing Data Collection form and Collection form		The Director of Nursing Se (DNS), or designee, will co monthly audits of tuberculo forms for all new admission the next 3 months to ensure are completing and dating the questionnaire form in accordance with our facility practice guidelines and regulatory requirements. Observation reports will be reviewed by the Risk Management/Quality Assure Committee until such time consistent substantial compliance has been achievant and determined by the committee committee until such time consistent substantial compliance has been achievant and determined by the committee until such time consistent substantial compliance has been achievant and determined by the committee until such time compliance has been achievant and determined by the committee until such time compliance has been achievant and determined by the committee until such time committee until such time compliance has been achievant and determined by the committee until such time committee until such time committee until such time compliance has been achievant and determined by the committee until such time committees and determined by the committee until such time committees and determined by the committees and determi	nduct sis for e staff he 's	
	R37's Admission Nursi dated 4/30/15, identified on 4/30/15. The TB so completed, however, ti	to identify if it had been ing Data Collection form ed R37 had been admitted creening form was				8/11/15
	During interview on 7/8	3/15. at 10:40 a m			-	

Minneso	ta Department of Healt	<u>h</u>				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00626	B. WING		07/	10/2015
NAME OF P	RÖVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
RELGRAI	DE NURSING HOME	103 SCH	OOL STREET,	PO BOX 340		
DELOKAL	DE NORSING FICHIE	BELGRA	DE, MN 56312			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	D BE COMPLETE	
21426	Continued From page	7	21426			
	screening for R40 was verified the date and s and R37's tuberculin r present, and stated sh	-A stated the tuberculin s not completed, and also signature on R5, R16, R21, risk assessment was not ne was unable to determine ompleted timely without a				
		osis Infection Control Plan but not received.				
	The director of nursing	OD OF CORRECTION: g could in-service all staff tion and documentation of				
21665	TIME PERIOD FOR C (21) days. MN Rule 4658.1400 P	ORRECTION: Twenty One	21665	Immediate action(s) take for the resident(s) found to have been affected include.	to	
	A nursing home must	provide a safe, clean, e, and homelike physical the resident to use		 The Director of Nursing Services met with the RNs. Safety and fall risk assessm were completed for Resider _40 Appropriate revisio 	nt#	
•	by: Based on observation, review, the facility faile	interview, and document d to ensure resident safety		were made to the care plan reflect all current safety interventions.	s to	
	and R30) who were ob equipment in need of r facility also failed to co	pair, for 2 of 2 residents (R5 served with mobility epair or adjustment. The		 Personal equipment for R and Rl# 30 were removed a repaired. These items were returned to the residents. 	ınd	

	ta Department of Healt		T		
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X	
			A. BUILDING:		COMPLETED
			B. WING		
		00626	B. WING		07/10/2015
NAME OF F	PROVIDER OR SUPPLIER	STREETAD	DRESS, CITY, ST	ATE, ZIP CODE	
BELCHAI	DE NURSING HOME	103 SCH	OOL STREET,	PO BOX 340	
BELGRA	DE NORSING HOME	BELGRA	DE, MN 56312		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
21665	Continued From page	8	21665	2 Identification of all	
	residents (R5) review	ed, who was identified as at		2. Identification of other	
	risk for falls.	ed, who was identified as at		residents having the pote	ntial
		•		to be affected was	
	Findings include:			accomplished by:	·
				• The pursing team resilence	ad
	R5's Medication Revie	ew Report dated 5/22/15,	1	The nursing team review the MDS Assessment for	
	identified diagnoses in	encluding Alzheimer's eneration, generalized pain	1	the MDS Assessments for a	All
	and personal history		4 1 July 2	residents who have been	
	·			identified as having a poten	
	R5's quarterly Minimu	m Data Set (MDS) dated	- W	risk for falls. Fall and safety	/ risk
		had severely impaired		assessments are complete	and
		ns and was independent		interventions currently in pla	ice
	with most activities of	daily living (ADLs).		are appropriate.	
	R5's care plan dated 6	6/17/15, identified R5 had a	*		
	self-care performance		-	The facility has determine	,d
	limitations related to w			that all residents with person	
	extremities, unsteading				
	ambulation, bilateral kr	nee pain, and not knowing		equipment have the potentia	al to
	her limitations. R5 wa	s independent with on, with the use of her		be affected.	
	cane or walker and sta	aff assistance as needed.			
		ntified R5 was at a high risk		3. Actions taken/systems	put -/
	for falls due to complain			into place to reduce the ris	
	standing, history of fall	s, poor vision, and frequent		future occurrence include:	1
		included encouragement to		All I	
		walker (4 WW) or cane with		 All Licensed Nursing staff 	Will
		e of a safe environment. Information from her past		be in-serviced on the facility	
		attempts to determine the		policy.	
	root cause, and if poss				
	potential causes.	, ,		All resident falls/accidents w	ill be
				reviewed by the nursing tear)
		1/15, at 7:15 a.m. authored		ensure appropriate	
	by licensed practical no	urse (LPN)-G identified R5		implementation of safety	
		e floor by her night stand.			
	WW and fell to the floo	ep while seated in her 4		interventions including update	ing
		ump to bor right tomple		the plan of care .	

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 00626 07/10/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET. PO BOX 340 **BELGRADE NURSING HOME** BELGRADE, MN 56312 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 21665 Continued From page 9 21665 All Licensed Nursing staff will No other injuries and no pain were noted. The be in-serviced on the need to incident report indicated the call light had fallen to inspect environmental items. 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 All personal resident equipment between that day and the day prior. LPN-G will be checked with every RN directed staff to monitor R5 for symptoms of a fall assessment. urinary tract infection (UTI) related to her incontinence, confusion, and this fall. At 12:01 p.m., registered nurse (RN)-G reviewed the fall, 4. How the corrective action(s) drawing a similar conclusion. RN-G directed staff will be monitored to ensure to continue to observe for signs of a UTI and the practice will not recur: update the physician as needed. She also initiated a three-day bowel and bladder The nursing management assessment, "... in case change in continence is team will review each incident related to an increase in dementia so that a report upon occurrence to toileting schedule may be made up." ensure appropriate interventions During observation on 7/7/15, at 3:54 p.m. R5 are implemented and updated was in her resident room seated on the bench of plan of care is complete. The her 4 WW, rolling the walker backward and **Director of Nursing Services** forward with her feet while she watched television. R5 motioned as though she was (DNS), or designee, will wanting to stand up from the seat, raising both complete random weekly chart her arms and shoulders to the handles of the audits for six (6) consecutive walker and pushing down on the handles to lift weeks and review all fall incident herself up. However, she quickly brought her arms back down and reached back to the walker reports to ensure that as she grasped the brake cables near the walker appropriate interventions have wheels, then moved her hands up the walker. been put in place to reduce the trying to manipulate various components of the walker, as it appeared R5 was trying to activate risk of resident falls/accidents the brakes of her 4 WW. When asked what she and that care plans have been was trying to do, R5 confirmed she was looking updated to reflect these for her brakes. After assisting her to locate and interventions. 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

Minneso	ta Department of Healt	h			1 01,41	WALL KOVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE S	
		•				
		00626	B. WING		07 <i>/</i>	10/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
		•	IOOL STREET,			
BELGRAI	DE NURSING HOME		ADE, MN 56312			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETE DATE
21665	Continued From page	10	21665	The Discotor of New York		
	lock the bilateral hand manually held the wal extensive assistance stood, the wheels of the to move with the shifti bench seat. After R5 able to ambulate out of LPN-H was asked who was were in working of the walker rolled back although the the brake LPN-H stated she had would put in a work or the brakes. The only R5's portion of her sha	lle brakes of the 4 WW and ker in place while providing for R5 to stand. As she he 4 WW again continued high of R5's weight from the was standing safely and of her room with her cane, either the brakes of the 4 brder. LPN-H demonstrated		 The Director of Nursing Services (DNS), or designe complete random audits for (6) consecutive weeks and review all fall incident repor- ensure that all resident equipment was in working of and was not the root cause accident. Audited records will be revie by the Risk Management/Qual Assurance Committee until time consistent substantial 	ts to order of an ewed uality such	
	Additional observation On 7/7/15, at 4:30 p.m her resident room, but	s included the following: R5's 4 WW remained in the brakes had still not		compliance has been achievas determined by the comm		8/12/15
	WW moved back and been removed from us at the time of this obse On 7/8/15, at 9:40 a.m R5's resident room, wi disrepair. The walker	. the 4 WW remained in th the brakes still in				
	p.m. the director of ma knowledge of R5's wal WW remained next to room as it had been du and DM activated the v immediately noticed th	uring all prior observations, walker brakes, he e wheels continued to ith ease and stated, "It				

<u>Minneso</u>	ta Department of Healt	h				
1	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMPI	
		00626	B. WING		07/	10/2015
NAME OF P	ROVIDER OR SUPPLIER	STREETAD	DRESS, CITY, ST	ATE, ZIP CODE		
BELGRAI	DE NURSING HOME		OOL STREET, DE, MN 56312	PO BOX 340	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
21665	Continued From page	11	21665			
	book, located at the nall staff were responsion concerns and filling out order request to address appropriate, and state	en in his work order request urse's station. DM stated ble for identifying safety at a maintenance work ess these concerns when d this request was not d no work order request had				
	During interview on 7/stated R5 mostly used but did use her 4 WW LPN-G stated R5's commonent to moment. LR5 utilize the bench se in her room, but she dibrakes were malfunctive recently fell from the swas the nurse on duty responded to the fall siby the nursing assistant was sitting on the floor the 4 WW behind her not evaluate the 4 WW determine whether it was	9/15, at 1:12 p.m. LPN-G I her cane for ambulation, while in her resident room. gnition varied greatly from LPN-G stated she had seen eat on the 4 WW as a chair enied having noticed the oning. LPN-G stated R5 eat of her 4 WW and she at the time of the fall and cene when called to assist nt (NA). LPN-G stated R5 of her resident room with LPN-G confirmed she did // at the time of the fall to // as in proper working order, lie RN was responsible for				
	During interview on 7/s director of nursing (DC safety devices were in the responsibility of all R5's post-fall assessm of RN-G who was on dRN-G was not available.	9/15, at 12:40 p.m. the PN) confirmed ensuring proper working order was employees. DON stated ent was the responsibility uty at the time of the fall. e for interview. Repair Request forms 7/9/15, lacked a work order				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 00626 07/10/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET. PO BOX 340 **BELGRADE NURSING HOME** BELGRADE, MN 56312 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) 21665 Continued From page 12 21665 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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(VO) MULTIPLE	E CONSTRUCTION	T.,,,,						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED							
			A. BUILDING:								
		00626	B. WING		07	/10/2015					
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, ST	TATE, ZIP CODE							
103 SCHOOL STREET, PO BOX 340											
BELGRAI	BELGRADE NURSING HOME BELGRADE, MN 56312										
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT		ION (X5)						
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE					
TAG REGULATORY OR LSC IDENTIFYING INFO		SCIDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE					
21665	Continued From page 13		21665	·							
	the wheelchair and the floor. The staff left the										
		sidents. The wheelchair									
		nti-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										
			Ì								
			1								
			1 .								
	tipping backwards.										
	On 7/0/45 at 40:45 a	D00	· ·		•						
	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					1					
		nd they should be turned			•						
		ney were currently on the									
	wheelchair. Divi imme	diately approached R30,									
	they were curved down	ars, and re-applied them so n. DM stated that R30's									
		e facility pre-assembled, so									
		hy the bars were turned									
		staff were responsible for									
	identifying safety conc										
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.										
	Deside at taken 1										
	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 wi	nairs. The DON stated th what anti-tip bars for									
		th what anti-tip pars for he could not speak to the									

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: R WING 00626 07/10/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET. PO BOX 340 **BELGRADE NURSING HOME** BELGRADE, MN 56312 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 21665 Continued From page 14 21665 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

Minneso	ta Department of Healt	<u>n</u>								
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
			A. BUILDING	· · · · · · · · · · · · · · · · · · ·						
00626		B. WING		07/10/2015						
NAME OF F	ROVIDER OR SUPPLIER	STREET	DDRESS CITY ST	TATE ZIP CODE	01/10/2013					
103 SCHOOL STREET PO BOX 340										
BELGRADE NURSING HOME 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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE					
21665	Continued From page 15		21665							
	over or lose control of the wheelchair and seriously injury yourself or others or damage the wheelchair."									
	The director of nursing educate staff regarding ensuring mobility deviously and/or assembled prodesignee, could coord housekeeping staff to	ces are working properly perly. The DON or linate with maintenance and conduct periodic audits of ent to ensure a safe, clean, se environment is								
21805	(14) days.	The state of the s	21805	1. Immediate action(s) tak for the resident(s) found t have been affected includ	o					
	Subd. 5. Courteous residents have the right courtesy and respect f	treatment. Patients and		The CNAs and RNs involve were immediately in-service the proper procedures for maintaining resident dignity during mealtimes.						
	by: Based on observation, review the facility failed dignity was maintained resident information du	is not met as evidenced interview, and document d to ensure each residents' d while discussing private uring the supper meal for 1 ing dining observation.		2. Identification of other residents having the potent to be affected was accomplished by: The facility has determined all residents requiring feeding assistance at meal times had the potential to be affected.	that					

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: 00626 07/10/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET. PO BOX 340 **BELGRADE NURSING HOME** BELGRADE, MN 56312 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 21805 Continued From page 16 21805 3. Actions taken/systems put R11's admission record dated 6/17/15, included into place to reduce the risk of diagnosis of Alzheimer's disease and dementia. future occurrence include: R11's admission Minimum Data Set (MDS) dated CNAs and other facility 6/24/15, indicated R11 was severely cognitively personnel involved in providing impaired, and required extensive assistance of feeding assistance to residents one to two staff with all activities of daily living (ADL's) and supervision with set up for meals. will be in-serviced on the proper procedures for assisting During an observation on 7/7/15, at 6:31 p.m. residents with meals to ensure R11 was eating in the dining room, with three other residents sitting at the table. Two staff resident dignity is maintained members, nursing assistant (NA)-B and NA-C, during mealtimes. were sitting at the table assisting the residents with their supper meal. NA-B stated, "I put [R11] 4. How the corrective action(s) in the bathroom and [R11] just sat there." At 6:36 will be monitored to ensure p.m., registered nurse (RN)-B was standing by R11's table, and commented how well R11 was the practice will not recur: eating. NA-B indicated R11 was hungry, and stated R11, "Sat and sat on the toilet the whole The Director of Nursing Services time I was on break." (DNS), or designee, will conduct random observations of staff During interview on 7/7/15, at 6:40 p.m. RN-B during mealtimes over the next stated, "Yeah, we probably shouldn't be talking about toileting someone at the supper table. I had three (3) months to ensure staff just commented that he was eating really well and are promoting and maintaining [NA-B] said when [R11] is restless, he usually resident dignity during mealtimes needs to be toileted." in accordance with our facility's During interview on 7/7/15, at 6:49 p.m. NA-B practice guidelines and verified her conversation with RN-B regarding regulatory requirements. 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

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 00626 07/10/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 103 SCHOOL STREET. PO BOX 340 **BELGRADE NURSING HOME** BELGRADE, MN 56312 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 21805 Continued From page 17 21805 Observation reports and here frequently...It's a constant...Don't share too validation checklists will be much information." reviewed by the Risk Management/Quality Assurance A review of the facility policy titled Quality of Life-Dignity dated 8/11, staff are directed to treat Committee until such time residents with dignity and respect at all times and consistent substantial to maintain an environment in which confidential compliance has been achieved clinical information is protected, including, "Verbal staff-to-staff communication...shall be conducted as determined by the committee. 8/12/15 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.