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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZGKE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00542

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245594**

2. STATE VENDOR OR MEDICAID NO. (L2) **220043100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GIL-MOR MANOR**
(L4) **96 THIRD STREET EAST**
(L5) **MORGAN, MN** (L6) **56266**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **10/06/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Connie Brady, HFE NE II 10/30/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/15/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **11/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 17, 2016

Ms. Terrie Frank, Administrator
Gil-Mor Manor
96 Third Street East
Morgan, MN 56266

RE: Project Number S5594027

Dear Ms. Frank:

On October 6, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by November 15, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 6, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 6, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to determine whether the half side rails attached to the bed frame were safe for 2 of 5 residents (R24, R25) who utilized half rails. Findings include: R24 During initial resident interview on 10/3/16, at 11:25 a.m. R24's bed was observed to have bilateral half (1/2) plastic bed rails at the head of	F 323	Based on observation, interview and documentation review the facility failed to determine whether the half side rails attached to the bed frame were safe for 2 of 5 residents (R24, R25) who utilized half rails. Immediately, the facility remove the side rail for both R24 and R25 and replaced with bed canes. The facility policy and procedure was revised by the administrator and includes assessment	10/25/16

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

Electronically Signed | 10/27/2016

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F 323	Continued From page 1 bed (HOB). During inspection of the rails the following was noted: excessive space between the bedrail and the HOB and between the mattress and the base of the bedrail (the egress side of the bed). It appeared to be a larger space than the recommended FDA dimensional guidance to reduce entrapment. Furthermore, the half bedrail was loosely connected to the bed, allowing excessive movement from it's center position when used. At this time, R24 verified the rail was loose when questioned. It was noted the other 1/2 bedrail was located on the side of the bed (left) which was pushed up against the wall. The Food and Drug Administration (FDA) guidance Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, date 3/10/06 identified the following dimensions for safe bed rail use: (1.) Zone 3- Space between mattress and base of bedrail should not exceed 4 3/4 inches when client lying in bed and placing weight on mattress (2.) Zone 6-Space between HOB and bedrail should not exceed 4 3/4 inches. During resident cares on 10/5/16, at 7:13 a.m. R24 was observed lying in his bed on his left side and had bilateral upper half rails raised. On 10/5/16, at 8:30 a.m. R24 sat on the bed independently and utilized the half siderail located on the upper left side of the bed to sit up and stand from bed. The rail was noted to move from side to side (loose connection to bed) when used. When interviewed on 10/6/16, at 11:00 a.m. R24 verified the half rail seemed loose (movement side/side) and at times, it would move from side to side during use. R24's quarterly Minimum Data Set (MDS) assessment, dated 8/19/16 identified R24 with a	F 323	procedures of those residents utilizing physical devices such as side rails/positioning devices. On October 25, 2016, education was provided to our Restorative RN who completes the side rail assessments. Additional education will be provided on the revised side rail policy and procedures to staff at the November 3, 2016 meeting. The Director of Nursing (or designee) will monitor the implementation of the revised side rail policy and procedures quarterly to monitor for safety and ensure that the facility is in compliance with entrapment guidelines and it will be reviewed at the quarterly Quality Assurance meetings. Completion date is October 25, 2016.	

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F 323	Continued From page 2 Brief Interview for Mental Status (BIMS) score of 15, identifying intact cognition. It identified R24 required supervision with physical assist of 1 staff for bed mobility and that R24 was not steady with surface to surface transfers. Documentation identified R24 sustained falls since the previous annual MDS assessment dated 5/27/16, and sustained minor injury. A Fall Risk assessment dated 8/19/16, identified R24 had sustained 1-2 falls in the past 6 months, had occasional incontinence and was prescribed medications which included: diuretic, hypoglycemia and antihypertensive meds that placed R24 at greater risk for falls, indicating at moderate risk for falling. Review of the Side Rail Utilization Assessment, dated 8/19/16, identified that R24 utilized two (2) half siderails for mobility and was capable to use the rails and a walker to transfer from bed independently; R24 had a history of falls on 3/7/15 and 12/6/15. Documentation identified R24 had not experienced entanglement nor entrapment with side rail use but the assessment failed to identify whether the bed rails were properly affixed to the bed and safe to use. R24's care plan dated 9/9/16, identified R24 with diagnoses that included: hypertension, diabetes, glaucoma, chronic ischemic heart disease, macular degeneration, spondylosis and muscle weakness. R24's care plan identified R24 at moderate risk for falling related to unsteady balance secondary to brain resection, history of fall and balance deficit. Interventions identified on the care plan to reduce fall risk included: (1.) Encourage use of call light, ask for assistance with increased weakness, pain or lethargy. (2.) Ensure appropriate footwear when ambulating and using walker.	F 323		

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F 323	Continued From page 3 (3.) Encourage to participate in activities that promote exercise. (4.) Physical activity for strengthening and improved mobility such as: ambulation. (5.) Restorative exercises program to help maintain level of function with transfers and ambulation. (6.) Encouraged to use walker, and if noting increased pain, weakness of legs or unsteadiness of gait, staff will report to physician resident need for evaluation. (7.) Staff will move chairs and furniture to where needed. (8.) Due to recent falls resident utilizes a reacher/grabber to assist with getting items that have dropped on floor. A progress note dated 9/25/16, at 6:45 a.m. identified R24 requested that staff check his left hip for bruising. R24 shared that he had fallen around 3:00 p.m. on 9/24/16, was able to get himself up from the floor but did not report the incident to any staff. Staff subsequently noted the following: left elbow-3.1 centimeter (cm) x 6.0 cm bruise; right upper hip-6.4 cm x 10.7 cm bruise; and right lower buttock-10.4 cm x 8.0 cm bruise. Post fall interventions included: ambulate with resident to all destination using the wheeled walker and follow with wheel chair, until stiffness and soreness resolves. During review of the Injury Incident Report dated 9/25/16, at 6:45 a.m. staff questioned R24 about the circumstances of the fall. R24 stated he was sleeping in his room (bed), lost his balance and fell after tripping over his walker. The report did not identify whether R24 was transferring from his bed at the time. On 9/26/16, at 5:59 p.m. a progress note identified R24 could walk only a few feet with 2 assist and then R24 would complain of left hip	F 323		

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F 323	Continued From page 4	F 323		

pain. On a scale of 1-10, R24 rated his pain at 8. After family notification, R24 was examined by the physician on 9/25/16, according to the 9/28/16, 10:45 a.m. progress note. No fractures were identified but R24 was diagnosed with skeletal and muscle strain and contusion of the left hip.

During interview with licensed practical nurse (LPN)-A and registered nurse (RN)-B on 10/5/16, at 11:47 a.m. staff stated bedrail assessments were conducted by RN-C. Both staff also stated that maintenance staff placed and/or removed the side rails on the beds. Both interviewed staff stated they were unaware of the loose fitting bed rail nor of the excessive spacing related to R24's half rails.

On 10/5/16, at 11:56 a.m. the bilateral 1/2 bedrails on R24's HOB bed were inspected with the maintenance (M)-A staff. During the observation M-A verified the spacing on the bed rails was wide between the HOB and the edge of bedrails and the mattress and the base of the bedrails. M-A further verified the bedrails were loose and not attached firmly to the bed frame. M-A stated he did not measure the space when placing rails on the beds but just placed the rails as directed by nursing staff.

On 10/5/16, at 11:57 a.m. nursing assistant (NA)-A verified R24 routinely utilized the bedrails to transfer from the bed.

During observation on 10/5/16, at 12:19 p.m. with RN-C, she indicated she had been unaware of the loose bedrails on R24's bed and had missed this issue while conducting the siderail assessment. RN-C also confirmed she had not evaluated the space measurements of the bedrails (safety issue) but only identified the resident's need for the use of the rails. RN-C verified the bedrails had been placed on R24's

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F 323	Continued From page 5 bed for several months and since the most recent annual MDS assessment dated May 2016. On 10/5/16, at 12:45 p.m. the director of nursing (DON) entered R24's room and measured the spacing of the bedrails. During the measurements it was noted space between the HOB and the top of the bedrail measured 7 inches. The space between the mattress and the base of the bedrail measured 6 1/2 inches; in addition, the side/side movement of the side rail from the point of attachment was 4 inches. The DON verified half rail was too loose which presented a safety risk for R24 due to a history of falls and unsteadiness. R25 During initial resident room observation on 10/5/16, at 12:45 p.m. it was noted that R25's bed had a 1/2 bedrail constructed of plastic at the HOB on the left side of the bed. This was located on the side of the bed R25 would egress. The other side of the bed was located up against the wall, with a grab bar attached. During inspection of the rail, it was noted the spacing of the rails between the rail and HOB, the space between the mattress and the base of the rail on the egress side of the bed appeared to be wider than the recommended dimension. Furthermore, the half rail appeared to be loosely connected to the bed and moved from side to side. The quarterly MDS assessment, dated 9/23/16, identified R25 with a BIMS score of 15, identifying intact cognition. Documentation also identified that R25 required extensive assistance of 2 staff to transfer, was not steady with surface to surface transfers and R25 had sustained falls since last quarterly annual MDS assessment dated 7/8/16 with no injury related to fall.	F 323		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 6	F 323		

The Side Rail Utilization Assessment dated 9/21/16, identified that R25 used a 1/2 siderails for mobility; a history of falls-on 10/24/15, 12/5/15, 6/22/16 and 9/10/16. Documentation identified that R25 was able to get out of bed at times, had poor balance and poor safety awareness. Documentation indicated no entanglement and/or entrapment in the rails had occurred but it did not indicate whether the rails had been properly affixed to the bed frame.
R25's care plan dated 10/3/16 identified R25 with diagnoses that included: Parkinson's disease, diabetes, major depression, chronic pain and osteoarthritis. R25's care plan identified R25 at high risk for falling (fall history) and declining condition related to Parkinson's disease and arthritis. Interventions identified on the care plan to reduce fall risk included:
(1.) Has chair alarm on w/c connected to the kiosk to alert staff.
(2.) Anti-roll back brakes on wheelchair as resident self transfers at times.
(3.) Maintain clutter free room.
(4.) Use walker appropriately.
(5.) Maintain commonly used items within reach.
(6.) Encouraged to call for assistance with ambulation and transfers at all times.
(7.) Maintain call sensors in wheelchair, recliner and bed.

The care plan related to bed mobility identified that R25 required extensive assistance (1-2 staff) to reposition and turn in bed and to get to/from lying position in bed. It also indicated that R25 had 1/2 side rail on one side (right) and an enabler/positioning bar/device on other side (left)of bed to aide in participating and/or assisting staff when moving in bed per physicians order for safety and to assist with bed mobility. The care

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	245594	A. BUILDING _____ B. WING _____	10/06/2016

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plan also included that staff should monitor for injury and/or entrapment related to side rail use.
During medical record review, a progress note dated 9/10/16, at 4:25 p.m. identified R25 started to lose her balance while ambulating from the bathroom with the use of a walker and one staff assist. The progress note documented that while exiting the doorway, R25 stated her right leg began to tremble causing her to lose her balance and she began to fall. Staff guided R25 to the floor. No injury was documented.
On 6/22/16, at 12:00 p.m. a progress note identified staff were assisting R25 to get up to use the bathroom when she lost her balance and staff were unable to prevent her from falling on her buttocks. No injury occurred.
When interviewed on 10/5/16, at 11:57 a.m. NA-A verified R25 utilized the bedrails to get out of bed.
On 10/5/16, at 12:45 p.m. the DON entered R25's room and measured the space between the bedrails. When measured, the space between the HOB and the top of the bedrail was 7 inches. The space between the mattress and the base of the bedrail measured 7 inches. Furthermore, the side to side movement of the bedrail from the central location was 4 inches. The DON verified the rail was too loose, which placed R25 at risk for falling due to her unsteadiness. The DON stated the space dimensions of the rail should be properly assessed to determine whether there was a risk for entrapment.

When interviewed on 10/6/16, at 7:58 a.m. R25 stated she had noticed how wobbly the side rail was and indicated it is kind of "Scary" when she used it to turn in bed or sit up on the edge of bed. R25 also stated she wasn't sure the rail was on the bed correctly.

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F 323	Continued From page 8 The undated facility policy "Proper Use of Side Rails", identified the facility would ensure safe use of side rails as resident mobility aids and prohibit use of side rails as a restraint unless necessary to treat a resident's medical condition. The policy identified the following criteria for side rail use: (1.) Side rails are considered a restraint when they are used to limit the resident's freedom of movement. (2.) Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents. (3.) An assessment will be made to determine the resident's symptoms or reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: a. Bed Mobility; b. Ability to change positions, transfer to and from bed or chair, and to stand and toilet. (4.) The use of the side rails as an assistive device will be addressed in the resident's care plan. (8.) When side rails usage is appropriate for the resident, assessment will be made of the space between the mattress and the side rails to reduce risk of entrapment. (no more than 4 3/4 inches) Tightness of side rails to reduce the risk of entrapment. (no more than 4 3/4 inches.) Tightness of side rails will be checked periodically by environmental services to ensure continued safety. (9.) The risks and benefits of side rails shall be considered for each resident. (10.) Consent for side rail use will be obtained from the resident or legal representative after presenting potential risks and benefits. (11.) The resident will be checked periodically for safety.	F 323		

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F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 334		10/25/16

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F 334	Continued From page 10 already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a policy and procedure related to the pneumococcal conjugate vaccine (PCV13) according to recommendations by the Centers for Disease Control (CDC) for 6 of 6 residents (R15, R21, R35, R36, R41, R42) whose vaccination histories were reviewed. Findings include: R15's Vaccination Record undated, indicated the	F 334	Based on interview and documentation review, the facility failed to implement a policy and procedure related to the pneumococcal conjugate vaccine (PCV13) according to recommendations by the Centers for Disease Control (CDC) for 6 of 6 residents (R15, R21, R35, R36, R41, R42) whose vaccination histories were reviewed. The Director of Nursing reviewed all	

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F 334	Continued From page 11 93 year old resident received the Pneumovax on 2/2/2009 per the MICC (Minnesota Immunization Information Connection) system . There was no evidence she had been offered the PCV13 vaccine since her admission to the facility 4/20/16. R21's Minimum Data Set (MDS) facility assessment form dated 1/14/15, indicated the 84 year old resident had not received the Pneumovax. It was noted on the assessment that R21 "never gets these vaccines." There was no evidence R21 had been offered the PCV13 vaccine since admission to the facility on 1/9/15. R35's Resident Vaccination Record dated 5/16/16, identified the 89 year old resident had never had a Pneumovax and "refuses". The MDS facility admission form dated 5/19/16, identified R35 had no record of a Pneumovax per the MIIC system. There was no evidence R35 had been offered the PCV13 vaccine since admission to the facility on 5/16/16. R36's Resident Vaccination Record undated, indicated the 84 year old resident was never offered refused the Pneumovax. The MDS facility assessment form dated 9/2/16, identified R36 had no record of a Pneumovax per the MIIC system, she refuses vaccines. There was no evidence R36 had been offered the PCV13 vaccine since admission to the facility on 8/27/16. R41's MDS facility assessment form dated 9/26/16, identified R41 had a Pneumovax 9/5/16. There was no evidence R41 had been offered the PCV13 vaccine since admission to the facility on 9/24/16.	F 334	current residents immunization records and identified residents that have not received the Pneumococcal vaccine and contacted the physician for an order to receive the vaccine. For all new admission we will follow the updated policy and procedures to ensure that all resident are offered the Pneumococcal vaccines. The administrator revised the Influenza and Pneumococcal Vaccination Policy and Procedure to include the following; SECTION 7: Life Safety SUBJECT: Influenza and Pneumococcal Vaccination Policy and Procedure EFFECTIVE DATE: 10/25/2016 Objective and Goal Gil-Mor Manor and Gil-Mor Haven s goal is to establish and maintain policies and procedures for the prevention and control of influenza and pneumococcal pneumonia that are based on CDC recommendations. 1. Increase rates of vaccination against influenza and pneumococcal pneumonia among our residents/tenants of Gil-Mor Manor and Gil-Mor Haven. 2. Increase rates of vaccination against influenza among employees of Gil-Mor Manor and Gil-Mor Haven, and 3. Improve the processes for managing influenza outbreaks and pneumonia among our residents/tenants of Gil-Mor Manor and Gil-Mor Haven. Strategy for Influenza and Pneumococcal Vaccinations 1. Upon admission review vaccination	

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F 334	Continued From page 12 R42' MDS facility assessment form dated 9/28/16, identified R42's wife was unsure if he had a Pneumovax and there was nothing on the MICC system. There was no evidence R42 had been offered the PCV 13 vaccine since admission to the facility on 9/26/16. During interview on 10/6/16, at 10:00 a.m. the director of nurses (DON) verified the facility did not have a policy regarding the PCV13 vaccine and did not offer the PCV13 vaccine to residents. The CDC recommendations indicated, "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of PCV13. The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose."	F 334	record 2. Use of MIIC website (Minnesota Immunization Information Connection) to research each resident□s immunization record 3. Use of a standard form to record all vaccine related information for each resident. 4. Implementation of standing orders. For the Pneumococcal Vaccine we will utilize the use of standing orders for administering Pneumococcal Vaccines (PCV13 and PPSV23). 5. During times of shortages, acquire vaccines from public health programs where available. 6. Offer influenza vaccine annually to all residents, tenants and employees according to CDC recommendations between October and March. 7. Offer Prevnar 13 or pheunococcal vaccine after review of resident/tenants immunization records Immunization Protocol 1. Making Vaccination a Standard Part of Admission. Integrating vaccination into the admission process enables nursing homes to address vaccination for every new resident in a routine, systematic manner. Gil-Mor Manor has incorporated vaccinations as part of the facilities standing orders in order to offer an efficient and consistent method to provide these vaccinations to each residents upon admission. 2. Collecting Uniform Data on Vaccinations. Gil-Mor utilizes the MIIC website to obtain vaccination records for each resident and files this information in	

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F 334	Continued From page 13	F 334	the medical record. 3. Facilitating Nursing Homes Access to Vaccines. Ensure that vaccines are readily available to administer at the nursing home or make arrangements for resident to receive vaccinations at his/her physician s office, whichever they prefer. 4. Enhancing Education about Vaccine Safety and Efficacy. Better understanding about vaccine safety and efficacy among nursing home residents, staff, physicians, and residents families can help to increase vaccination in nursing homes. Provide education about the benefits and risks of vaccination to residents or their legal representatives. 5. Obtain Consent from resident of legal representative for immunizations as well as his or her physician. Gil-Mor Manor and Gil-Mor Haven will preserve Residents Rights in the event that a resident and/or physician does not consent to immunizations, however, 6. The Medical Director will be available to provide guidance as well as intervene if practitioners do not comply with our policy and procedures for immunizations. In the event of an outbreak, Gil-Mor Manor and Gil-Mor Haven will implement outbreak control measures according to CDC guidelines and recommendations. The Director of Nursing (or designee) will review all new admissions on a quarterly basis to ensure compliance in offering the influenza and pneumococcal immunizations and report finds at the Quality Assurance Meeting. Plan of correction completion date is October 25, 2016.	

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS FORM-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on October 4, 2016. At the time of this survey, Gil-Mor Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/27/2016

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Gil-Mor Manor was constructed as follows: The original building was constructed in 1963, is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 1989 building addition is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction.	K 000		
K 011 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire	K 011		10/25/16

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K 011	Continued From page 2 resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to provide a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2. This deficient practice could affect 30 of the 30 residents, visitors and staff. FINDINGS INCLUDE: On 10/04/2016 between 11:00 AM and 1:00 PM, based on observation and interview the following was observed: 1.) A penetration around electrical wires above the lay-in ceiling at the 2 hour fire wall between Gil-Mor Manor and the Haven Assisted Living was observed. 2.) The door in the 2 hour fire wall between Gil-Mor Manor and the Haven Assisted Living did not not latch into the frame when closed. This deficient practice was verfied by the Maintenance Supervisor.	K 011	Following the Fire Marshal exit, the Maintenance staff adjusted the door between Gil-Mor Manor and Gil-Mor Haven so the door could latch appropriately when closed. The Maintenance staff ordered the fire caulking that was not done following the electrical work done during the wireless call light and wanderguard installation. The fire caulking was completed on October 25, 2016, after the supply was received from the vendor. The plan of correction was completed on October 25, 2016.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,	K 052		10/25/16

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K 052	Continued From page 3 This STANDARD is not met as evidenced by: Based on documentation review and interview The facility failed to test and maintain the fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7. This deficient practice could affect 30 of the 30 residents, visitors and staff. FINDINGS INCLUDE: During review of fire alarm documentation on 10/04/2016 between 11:00 AM and 1:00 PM, it was revealed that documentation could not be provided to indicate that the DACT system was tested on a monthly basis during the evening or night fire drills. This deficient practice was observed by the Maintenance Director.	K 052	Following the Fire Marshal visit on 10/04/2016, the Maintenance staff scheduled the DACT system tests in conjunction with the facilities monthly fire drills to be rotating amongst all three shifts. 1. For the day shift, the DACT system test will be conducted immediately following the fire drill. 2. For the evening shift, the DACT system test will be conducted the DACT system will be tested prior to the actual fire drill conducted. 3. For those fire drills held during the overnight shift, the Maintenance staff will test the DACT system the following morning when they arrive to work. This will ensure that this system is tested every month covering all three shifts. Then on a quarterly basis at the QA&A meeting, the Maintenance staff will bring the Fire Drill Documentation book to ensure that the DACT system was tested according to requirements on all three shifts.	

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
October 17, 2016

Ms. Terrie Frank, Administrator
Gil-Mor Manor
96 Third Street East
Morgan, MN 56266

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5594027

Dear Ms. Frank:

The above facility was surveyed on October 3, 2016 through October 6, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the

correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Kathryn Serie, Unit Supervisor at (507) 476-4233.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00542	A. BUILDING: _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On October 3 throught October 6, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to determine whether the half side rails attached to the bed frame were safe for 2 of 5 residents (R24, R25) who utilized half rails. Findings include: R24 During initial resident interview on 10/3/16, at 11:25 a.m. R24's bed was observed to have bilateral half (1/2) plastic bed rails at the head of bed (HOB). During inspection of the rails the	2 830	Corrected	10/25/16

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2 830	Continued From page 3 following was noted: excessive space between the bedrail and the HOB and between the mattress and the base of the bedrail (the egress side of the bed). It appeared to be a larger space than the recommended FDA dimensional guidance to reduce entrapment. Furthermore, the half bedrail was loosely connected to the bed, allowing excessive movement from it's center position when used. At this time, R24 verified the rail was loose when questioned. It was noted the other 1/2 bedrail was located on the side of the bed (left) which was pushed up against the wall. The Food and Drug Administration (FDA) guidance Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, date 3/10/06 identified the following dimensions for safe bed rail use: (1.) Zone 3- Space between mattress and base of bedrail should not exceed 4 3/4 inches when client lying in bed and placing weight on mattress (2.) Zone 6-Space between HOB and bedrail should not exceed 4 3/4 inches. During resident cares on 10/5/16, at 7:13 a.m. R24 was observed lying in his bed on his left side and had bilateral upper half rails raised. On 10/5/16, at 8:30 a.m. R24 sat on the bed independently and utilized the half siderail located on the upper left side of the bed to sit up and stand from bed. The rail was noted to move from side to side (loose connection to bed) when used. When interviewed on 10/6/16, at 11:00 a.m. R24 verified the half rail seemed loose (movement side/side) and at times, it would move from side to side during use. R24's quarterly Minimum Data Set (MDS) assessment, dated 8/19/16 identified R24 with a Brief Interview for Mental Status (BIMS) score of 15, identifying intact cognition. It identified R24	2 830		

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2 830	Continued From page 4	2 830		

required supervision with physical assist of 1 staff for bed mobility and that R24 was not steady with surface to surface transfers. Documentation identified R24 sustained falls since the previous annual MDS assessment dated 5/27/16, and sustained minor injury.

A Fall Risk assessment dated 8/19/16, identified R24 had sustained 1-2 falls in the past 6 months, had occasional incontinence and was prescribed medications which included: diuretic, hypoglycemia and antihypertensive meds that placed R24 at greater risk for falls, indicating at moderate risk for falling.
Review of the Side Rail Utilization Assessment, dated 8/19/16, identified that R24 utilized two (2) half siderails for mobility and was capable to use the rails and a walker to transfer from bed independently; R24 had a history of falls on 3/7/15 and 12/6/15. Documentation identified R24 had not experienced entanglement nor entrapment with side rail use but the assessment failed to identify whether the bed rails were properly affixed to the bed and safe to use.
R24's care plan dated 9/9/16, identified R24 with diagnoses that included: hypertension, diabetes, glaucoma, chronic ischemic heart disease, macular degeneration, spondylosis and muscle weakness. R24's care plan identified R24 at moderate risk for falling related to unsteady balance secondary to brain resection, history of fall and balance deficit. Interventions identified on the care plan to reduce fall risk included:
(1.) Encourage use of call light, ask for assistance with increased weakness, pain or lethargy. (2.) Ensure appropriate footwear when ambulating and using walker.
(3.) Encourage to participate in activities that promote exercise.
(4.) Physical activity for strengthening and

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2 830	Continued From page 5 improved mobility such as: ambulation. (5.) Restorative exercises program to help maintain level of function with transfers and ambulation. (6.) Encouraged to use walker, and if noting increased pain, weakness of legs or unsteadiness of gait, staff will report to physician resident need for evaluation. (7.) Staff will move chairs and furniture to where needed. (8.) Due to recent falls resident utilizes a reacher/grabber to assist with getting items that have dropped on floor. A progress note dated 9/25/16, at 6:45 a.m. identified R24 requested that staff check his left hip for bruising. R24 shared that he had fallen around 3:00 p.m. on 9/24/16, was able to get himself up from the floor but did not report the incident to any staff. Staff subsequently noted the following: left elbow-3.1 centimeter (cm) x 6.0 cm bruise; right upper hip-6.4 cm x 10.7 cm bruise; and right lower buttock-10.4 cm x 8.0 cm bruise. Post fall interventions included: ambulate with resident to all destination using the wheeled walker and follow with wheel chair, until stiffness and soreness resolves. During review of the Injury Incident Report dated 9/25/16, at 6:45 a.m. staff questioned R24 about the circumstances of the fall. R24 stated he was sleeping in his room (bed), lost his balance and fell after tripping over his walker. The report did not identify whether R24 was transferring from his bed at the time. On 9/26/16, at 5:59 p.m. a progress note identified R24 could walk only a few feet with 2 assist and then R24 would complain of left hip pain. On a scale of 1-10, R24 rated his pain at 8. After family notification, R24 was examined by the physician on 9/25/16, according to the 9/28/16, 10:45 a.m. progress note. No fractures	2 830		

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2 830	Continued From page 6 were identified but R24 was diagnosed with skeletal and muscle strain and contusion of the left hip. During interview with licensed practical nurse (LPN)-A and registered nurse (RN)-B on 10/5/16, at 11:47 a.m. staff stated bedrail assessments were conducted by RN-C. Both staff also stated that maintenance staff placed and/or removed the side rails on the beds. Both interviewed staff stated they were unaware of the loose fitting bed rail nor of the excessive spacing related to R24's half rails. On 10/5/16, at 11:56 a.m. the bilateral 1/2 bedrails on R24's HOB bed were inspected with the maintenance (M)-A staff. During the observation M-A verified the spacing on the bed rails was wide between the HOB and the edge of bedrails and the mattress and the base of the bedrails. M-A further verified the bedrails were loose and not attached firmly to the bed frame. M-A stated he did not measure the space when placing rails on the beds but just placed the rails as directed by nursing staff. On 10/5/16, at 11:57 a.m. nursing assistant (NA)-A verified R24 routinely utilized the bedrails to transfer from the bed. During observation on 10/5/16, at 12:19 p.m. with RN-C, she indicated she had been unaware of the loose bedrails on R24's bed and had missed this issue while conducting the siderail assessment. RN-C also confirmed she had not evaluated the space measurements of the bedrails (safety issue) but only identified the resident's need for the use of the rails. RN-C verified the bedrails had been placed on R24's bed for several months and since the most recent annual MDS assessment dated May 2016. On 10/5/16, at 12:45 p.m. the director of nursing (DON) entered R24's room and measured the spacing of the bedrails. During the	2 830		

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2 830	Continued From page 7 measurements it was noted space between the HOB and the top of the bedrail measured 7 inches. The space between the mattress and the base of the bedrail measured 6 1/2 inches; in addition, the side/side movement of the side rail from the point of attachment was 4 inches. The DON verified half rail was too loose which presented a safety risk for R24 due to a history of falls and unsteadiness. R25 During initial resident room observation on 10/5/16, at 12:45 p.m. it was noted that R25's bed had a 1/2 bedrail constructed of plastic at the HOB on the left side of the bed. This was located on the side of the bed R25 would egress. The other side of the bed was located up against the wall, with a grab bar attached. During inspection of the rail, it was noted the spacing of the rails between the rail and HOB, the space between the mattress and the base of the rail on the egress side of the bed appeared to be wider than the recommended dimension. Furthermore, the half rail appeared to be loosely connected to the bed and moved from side to side. The quarterly MDS assessment, dated 9/23/16, identified R25 with a BIMS score of 15, identifying intact cognition. Documentation also identified that R25 required extensive assistance of 2 staff to transfer, was not steady with surface to surface transfers and R25 had sustained falls since last quarterly annual MDS assessment dated 7/8/16 with no injury related to fall. The Side Rail Utilization Assessment dated 9/21/16, identified that R25 used a 1/2 siderails for mobility; a history of falls-on 10/24/15, 12/5/15, 6/22/16 and 9/10/16. Documentation identified that R25 was able to get out of bed at times, had poor balance and poor safety awareness.	2 830		

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2 830	Continued From page 8 Documentation indicated no entanglement and/or entrapment in the rails had occurred but it did not indicate whether the rails had been properly affixed to the bed frame. R25's care plan dated 10/3/16 identified R25 with diagnoses that included: Parkinson's disease, diabetes, major depression, chronic pain and osteoarthritis. R25's care plan identified R25 at high risk for falling (fall history) and declining condition related to Parkinson's disease and arthritis. Interventions identified on the care plan to reduce fall risk included: (1.) Has chair alarm on w/c connected to the kiosk to alert staff. (2.) Anti-roll back brakes on wheelchair as resident self transfers at times. (3.) Maintain clutter free room. (4.) Use walker appropriately. (5.) Maintain commonly used items within reach. (6.) Encouraged to call for assistance with ambulation and transfers at all times. (7.) Maintain call sensors in wheelchair, recliner and bed. The care plan related to bed mobility identified that R25 required extensive assistance (1-2 staff) to reposition and turn in bed and to get to/from lying position in bed. It also indicated that R25 had 1/2 side rail on one side (right) and an enabler/positioning bar/device on other side (left)of bed to aide in participating and/or assisting staff when moving in bed per physicians order for safety and to assist with bed mobility. The care plan also included that staff should monitor for injury and/or entrapment related to side rail use. During medical record review, a progress note dated 9/10/16, at 4:25 p.m. identified R25 started to lose her balance while ambulating from the bathroom with the use of a walker and one staff assist. The progress note documented that	2 830		

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2 830	Continued From page 9 while exiting the doorway, R25 stated her right leg began to tremble causing her to lose her balance and she began to fall. Staff guided R25 to the floor. No injury was documented. On 6/22/16, at 12:00 p.m. a progress note identified staff were assisting R25 to get up to use the bathroom when she lost her balance and staff were unable to prevent her from falling on her buttocks. No injury occurred. When interviewed on 10/5/16, at 11:57 a.m. NA-A verified R25 utilized the bedrails to get out of bed. On 10/5/16, at 12:45 p.m. the DON entered R25's room and measured the space between the bedrails. When measured, the space between the HOB and the top of the bedrail was 7 inches. The space between the mattress and the base of the bedrail measured 7 inches. Furthermore, the side to side movement of the bedrail from the central location was 4 inches. The DON verified the rail was too loose, which placed R25 at risk for falling due to her unsteadiness. The DON stated the space dimensions of the rail should be properly assessed to determine whether there was a risk for entrapment. When interviewed on 10/6/16, at 7:58 a.m. R25 stated she had noticed how wobbly the side rail was and indicated it is kind of "Scary" when she used it to turn in bed or sit up on the edge of bed. R25 also stated she wasn't sure the rail was on the bed correctly. The undated facility policy "Proper Use of Side Rails", identified the facility would ensure safe use of side rails as resident mobility aids and prohibit use of side rails as a restraint unless necessary to treat a resident's medical condition. The policy identified the following criteria for side rail use: (1.) Side rails are considered a restraint when	2 830		

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2 830	Continued From page 10 they are used to limit the resident's freedom of movement. (2.) Side rails are only permissible if they are used to treat a resident's medical symptoms or to assist with mobility and transfer of residents. (3.) An assessment will be made to determine the resident's symptoms or reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's: a. Bed Mobility; b. Ability to change positions, transfer to and from bed or chair, and to stand and toilet. (4.) The use of the side rails as an assistive device will be addressed in the resident's care plan. (8.) When side rails usage is appropriate for the resident, assessment will be made of the space between the mattress and the side rails to reduce risk of entrapment. (no more than 4 3/4 inches) Tightness of side rails to reduce the risk of entrapment. (no more than 4 3/4 inches.) Tightness of side rails will be checked periodically by environmental services to ensure continued safety. (9.) The risks and benefits of side rails shall be considered for each resident. (10.) Consent for side rail use will be obtained from the resident or legal representative after presenting potential risks and benefits. (11.) The resident will be checked periodically for safety. SUGGESTED METHOD OF CORRECTION: The administrator or designee could update facility policies and procedures related to accurate assessment of residents utilizing physical devices, train staff on the new policies and monitor implementation of the policies. TIME PERIOD FOR CORRECTION: Twenty One	2 830		

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2 830	Continued From page 11 (21) days.	2 830		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to screen 6 of 6 newly admitted residents (R15, R21, R35, R36, R41, R42) for symptoms of tuberculosis (TB). Findings include: R15 was admitted to the facility 4/20/15. A review of the TB test results identified a two step	21426	Corrected	10/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00542	A. BUILDING: _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	96 THIRD STREET EAST MORGAN, MN 56266

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21426	Continued From page 12 tuberculin skin test (TST) was completed 4/20/15 and 5/6/15. No symptom screen was found in the medical record. R21 was admitted to the facility 1/9/15. A review of the TB test results identified R21 refused the TST and a chest x ray was completed on 1/2/16. No symptom screening was found in the medical record. R35 was admitted to the facility 5/16/16. A review of the TB test results identified a two step TST was completed 5/16/16 and 5/23/16. No symptom screening was found in the medical record. R36 was admitted to the facility 8/27/16. A review of the TB test results identified a two step TST was completed 8/31/16 and 9/18/16. No symptom screening was found in the medical record. R41 was admitted to the facility 9/24/16. A review of the TB test results identified a two step TST was completed 9/24/16 and scheduled for 10/10/16. No symptom screening was found in the medical record. R42 was admitted to the facility 9/26/16. A review of the TB test results identified a two step TST was completed 9/20/16 and 10/4/16. No symptom screening was found in the medical record. When interviewed on 10/10/16, at 10:00 a.m. the director of nursing verified no symptom screening for tuberculosis had been completed for R15, R21, R35, R36, R41 and R42. She stated the facility did not conduct symptom screenings for residents related to tuberculosis.	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21426	Continued From page 13 The facility TB Control Plan dated 2013, did not identify symptom screening to be done on residents upon admission. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and the TB screening process. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		