#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: ZNE5

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PARII	- TO BE COMPLETE	D BY THE STAT	E SURVEY AGENCY	Fac	ility ID: 00065
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245328     ASSETTE MENDOR OR MEDICAID NO.	3. NAME AND ADDRES (L3) THE MARGARE (L4) 28210 OLD TOWN	Γ S PARMLY RESI	IDENCE	4. TYPE OF ACTION:  1. Initial	7 (L8) 2. Recertification
2.STATE VENDOR OR MEDICAID NO. (L2) <b>427240400</b>	(L5) CHISAGO CITY,		(L6) <b>55013</b>	3. Termination 5. Validation	4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIED  10 Hospital  10 Hospital		02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey After Co	9. Other omplaint
6. DATE OF SURVEY 11/18/2015 (L34)  8. ACCREDITATION STATUS: (L10)  0 Unaccredited	02 SNF/NF/Dual 06 Pl 03 SNF/NF/Distinct 07 X 04 SNF 08 O		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 101 (L18)  13. Total Certified Beds 101 (L17)	10.THE FACILITY IS CE  X A. In Compliance With Program Requirent Compliance Based 1. Acceptate  B. Not in Compliance Requirements and	th ments d On: ole POC	And/Or Approved Waivers Of T  2. Technical Personnel  3. 24 Hour RN  4. 7-Day RN (Rural SNI  5. Life Safety Code  * Code:  A*	6. Scope of Servic 7. Medical Direct	ces Limit or
14. LTC CERTIFIED BED BREAKDOWN			15. FACILITY MEETS		
18 SNF 18/19 SNF 19 SNF 101 (L37) (L38) (L39)	ICF (L42)	IID (L43)	1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARKS (IF APPLIC		, ,			
See Attached Remarks					
17. SURVEYOR SIGNATURE	Date :		18. STATE SURVEY AGENCY	APPROVAL	Date:
Kathy Sass, HFE NEII	12/02/2	(L19)	Mark Meath,	Enforcement Specialis	o1/06/2016 (L20
PART II - TO BI	COMPLETED BY HO	CFA REGIONAL	OFFICE OR SINGLE ST	TATE AGENCY	
DETERMINATION OF ELIGIBILITY      1. Facility is Eligible to Participate     2. Facility is not Eligible  (L21)	20. COMPLIAN RIGHTS AC	ICE WITH CIVIL T:	<ul><li>21. 1. Statement of Finan</li><li>2. Ownership/Control</li><li>3. Both of the Above</li></ul>	I Interest Disclosure Stmt (HC	CFA-1513)
22. ORIGINAL DATE 23. LTC AGRE	EMENT 24 LTC	AGREEMENT	26. TERMINATION ACTION:	(L3)	0)
OF PARTICIPATION BEGINNII 07/01/1986		DING DATE	VOLUNTARY 00 01-Merger, Closure	INVOLUNTA 05-Fail to Med	
(L24) (L41)	(L25	5)	02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Termination	00 1 411 10 1110	et Agreement
A. Suspens	,	44)	04-Other Reason for Withdrawal	OTHER 07-Provider S 00-Active	tatus Change
B. Rescind	Suspension Date: (L	.45)			
28. TERMINATION DATE:	29. INTERMEDIARY/CARR		30. REMARKS		
	03001				
(L28)		(L31)			
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF AF	PPROVAL DATE			
(L32)	11/13/2015	(L33)	DETERMINATION APPR	ROVAL	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00065

**C&T REMARKS - CMS 1539 FORM** 

CCN: 5328

STATE AGENCY REMARKS

On November 18, 2015 a Post Certification Revisit was completed by the Minnesota Department of Healths Licensing and Certification Program and Office of Health Facility Complaints (Investigiation of complaint number H53289019) and found deficiencies issued pursuant to the September 17, 2015 standard survey and the October 22, 2105 Abbreviated standard survey, effective Novembe 12, 2015. Refer to the CMS 2567b forms for the results of this visit.

Effective November 12, 2015, the facility is certified for 101 skilled nursing facility beds.



CMS Certification Number (CCN): 245328

January 6, 2016

Ms. Julie Spiers, Administrator The Margaret S Parmly Residence 28210 Old Towne Road Chisago City, Minnesota 55013

Dear Ms. Spiers:

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 November 12, 2015 the above facility is certified for or recommended for:

**Skilled Nursing Facility Beds** 

101 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 101 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697



Electronically delivered December 2, 2015

Ms. Julie Spiers, Administrator The Margaret S Parmly Residence 28210 Old Towne Road Chisago City, Minnesota 55013

RE: Project Number S5328023, H5328019

Dear Ms. Spiers:

On November 2, 2015, we informed you that the following enforcement remedy was being imposed:

• State monitoring effective November 7, 2015. (42 CFR 488.422)

In addition, on November 2, 2015, as authorized by CMS Region V office, the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 17, 2015. (42 CFR 488.417 (b))

Furthermore, we notified you in our letter of November 2, 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 December 17, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on September 17, 2015 and an abbreviated standard survey completed on October 22, 2015. The most serious deficiencies in your facility at the time of both the standard and abbreviated standard surveys were 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 November 18, 2015 and November 20, 2015, the Minnesota Department of Health, Licensing and Certification Program and Office of Health Facility Complaints completed a Post Certification Revisit PCR and on November 10, 2015, the Minnesota Department of Public Safety 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 September 17, 2015 and an abbreviated standard survey completed on October 22, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 12, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 17, 2015, as of November 12, 2015.

As a result of the PCR findings, this Department is discontinuing the Category 1 remedy of State monitoring as of November 12, 2015.

In addition, we recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of November 2, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 17, 2015, be rescinded. (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 December 17, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective December 17, 2015, is to be rescinded.

In our letter of November 2, 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 December 17, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 12, 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 related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

### 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 245328	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 11/18/2015
Name of Facility			Street Address, City, State, Zip Code	
THE MARGARET S PARMLY RESIDENCE			28210 OLD TOWNE ROAD	
			CHISAGO CITY, MN 55013	

(Y4) Item		(Y5)	Date	(Y4)	Item	(Y5)	Date	()	(4) Item	(	Y5) I	Date
ID Prefix	F0278		Correction Completed 10/15/2015		ID Prefix	F0280	Correction Completed 10/15/2015		ID Prefix	F0282		Correction Completed 10/15/2015
	483.20(g) - (j)		_ 10/10/2010			483.20(d)(3), 483.10(k)(2)	_ 10/10/2010			483.20(k)(3)(ii)		_ 10/10/2010
LSC	403.20(g) - (j)		-		LSC	403.20(U)(3), 403.10(K)(2)	_		LSC			_
			•	<del>                                     </del>					_			_
			Correction				Correction					Correction
ID Prefix	E0242		Completed 10/15/2015		ID Prefix	E0244	Completed 10/15/2015		ID Profix	F0315		Completed 10/15/2015
	-		_ 10/15/2015				_ 10/15/2015					
keg. #	483.25(a)(3)		-		keg. #	483.25(c)	_			483.25(d)		_
			-	-								_
			Correction				Correction					Correction
ID Prefix	F0371		Completed 10/15/2015		ID Prefix	F0456	Completed 10/16/2015		ID Prefix	F0465		Completed 10/15/2015
			_ 10/13/2013				_ 10/10/2013			-		
LSC	483.35(i)		-		LSC	483.70(c)(2)	_		LSC	483.70(h)		_
			-	-								<del>-</del>
			Correction				Correction					Correction
ID Prefix	F0514		Completed 10/15/2015		ID Prefix		Completed		ID Prefix			Completed
	483.75(I)(1)		_ 10/10/2010		Reg. #							
LSC			-		LSC		_		LSC			_
				1								
			Correction				Correction					Correction
ID Prefix			Completed		ID Prefix		Completed		ID Prefix			Completed
Reg. #					Reg. #							
LSC					LSC				LSC			_
Reviewed By	<i>'</i>	Reviewed I	-		te:	Signature of Surv					Date:	. / 0 0 1 5
State Agency	y	GL/mn	n	1.	1/25/20	015 31	223				11/18	3/2015
Reviewed By	<i>'</i> ——	Reviewed I	Ву	Da	te:	Signature of Surv	eyor:				Date:	
CMS RO												
Followup to Survey Completed on:						-				a Summary of		
	9/17/	2015				Uncorrecto	eu Denciencie	:5 (C	, IVI 3-230 / ) 3ent	to the Facility?	YES	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 245328	( <b>Y2) Multiple Constru</b> A. Building B. Wing	N BUILDING 01	(Y3) Date of Revisit 11/10/2015
Name	of Facility		Street Address, City, State, Zip Code	
TH	E MARGARET S PARMLY RESIDENCE		28210 OLD TOWNE ROAD	
			CHISAGO CITY, MN 55013	

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5	5)	Date	(Y4	) Item		(Y5)	Date
			Correction					(	Correction					Correction
			Completed						Completed					Completed
ID Prefix			10/15/2015		ID Prefix				10/15/2015		ID Prefix			10/15/2015
Reg.#	NFPA 101				Reg. #	NFPA 1	101				Reg. #	NFPA 101		
LSC	K0011		•		LSC	K0017					LSC	K0018		_
			Correction					(	Correction					Correction
			Completed						Completed					Completed
ID Prefix			10/15/2015		ID Prefix				10/15/2015		ID Prefix			10/15/2015
•	NFPA 101		_		Reg.#	NFPA 1	101				•	NFPA 101		
LSC	K0029				LSC	K0046					LSC	K0050		_
			Correction					(	Correction					Correction
			Completed						Completed					Completed
ID Prefix	-		10/15/2015		ID Prefix	-			10/15/2015		ID Prefix			10/15/2015
•	NFPA 101				ū	NFPA 1		_			ū	NFPA 101		
LSC	K0052				LSC	K0054					LSC	K0056		
			Correction					(	Correction					Correction
ID Prefix			Completed 10/15/2015		ID Prefix				Completed 10/15/2015		ID Profix	[		Completed 10/15/2015
			10/13/2013					_	10/13/2013					
ū	NFPA 101		-		•	NFPA 1		_			ū	NFPA 101		_
	K0062			_	LSC	K0064		_				K0067		
			0					,	0					0
			Correction						Correction					Correction
ID Prefix			Completed 10/15/2015		ID Prefix				Completed 10/15/2015		ID Prefix			Completed 10/15/2015
Rea #	NFPA 101		-			NFPA 1						NFPA 101		_
-	K0069		-		-	K0076		_			-	K0144		_
				+				_						
Reviewed By		Reviewed E	 3y	Da	te:		Signature of Surv	vey	or:				Date:	
State Agency	y	TL/mr	n	11	/25/20	15	2	27	200				11/	10/2015
Reviewed By	,	Reviewed E	Зу		te:		Signature of Surv	vey	or:				Date:	
CMS RO														

Form Approved
OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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(Y1)	Provider / Supplier / CLIA / Identification Number 245328	(Y2) Multiple Constru A. Building B. Wing	N BUILDING 01	(Y3) Date of Revisit 11/10/2015
Name	of Facility		Street Address, City, State, Zip Code	
TH	E MARGARET S PARMLY RESIDENCE		28210 OLD TOWNE ROAD	
			CHISAGO CITY, MN 55013	

(Y4) Item		(Y5)	Date	(Y4) Ite	m			(Y5)	Date	(Y4	) Item			(Y5)	Date
			Correction						Correction						Correction
10.0.5			Completed						Completed		15.5	-			Completed
ID Prefix			10/15/2015	ID I	Prefix				10/15/2015		ID Pre		-		10/15/2015
_	NFPA 101			R	-	NFPA 101							NFPA 101		
LSC	K0147				LSC	K0154				$\perp$	L	sc	K0155		
		I													
Reviewed By	<u> </u>	Reviewed E	Ву	Date:		Sig	gnature of	Surve	yor:					Date:	
State Agenc	/	TL/mn	1	11/25	/201	5		27	200					11/	10/2015
Reviewed By	· ——	Reviewed E	Зу	Date:		Siç	gnature of	Surve	yor:					Date:	
CMS RO															
Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of						:							
9/21/2015		Uncorrected Deficiencies (CMS-2567) Sent to the Facility?						NO							
				1											

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 245328	(Y2) Multiple Constr A. Building B. Wing	MARGARET S. PARMLEY RESIDENCE	(Y3) Date of Revisit 11/10/2015
Name	of Facility		Street Address, City, State, Zip Code	
T⊢	E MARGARET S PARMLY RESIDENCE		28210 OLD TOWNE ROAD	
			CHISAGO CITY, MN 55013	

(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4	) Item		(Y5)	Date
			Correction					Correction					Correction
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ID Prefix			10/15/2015					10/15/2015					10/15/2015
ū	NFPA 101				-	NFPA 101				•	NFPA 101		_
	K0029			<u> </u>	LSC	K0046			_	LSC	K0050		_
			Correction					Correction					Correction
			Correction Completed					Completed					Correction Completed
ID Prefix			10/15/2015		ID Prefix			10/15/2015		ID Prefix			10/15/2015
Reg. #	NFPA 101				Reg. #	NFPA 101				Reg. #	NFPA 101		
LSC	K0052		•		LSC	K0054		•		LSC	K0056		_
			Correction					Correction					Correction
ID Prefix			Completed 10/15/2015		ID Prefix			Completed <b>10/15/2015</b>		ID Prefix			Completed 10/15/2015
	NEDA 404		-					-					
•	NFPA 101 K0062				•	NFPA 101 K0064					NFPA 101 K0067		_
	110002			-		110001			_		110001		<u> </u>
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			10/15/2015		ID Prefix			10/15/2015		ID Prefix			10/15/2015
Reg. #	NFPA 101		<u>.</u>		Reg. #	NFPA 101				-	NFPA 101		_
LSC	K0075				LSC	K0144			$\perp$	LSC	K0154		_
			Correction					Correction					Correction
ID Prefix			Completed 10/15/2015		ID Prefix			Completed		ID Prefix			Completed
Rea.#	NFPA 101		-		Reg. #					D #			
_	K0155		-		LSC					LSC			_
				_					$^{+}$				
Reviewed By		Reviewed E	Зу	Da	te:	Signa	ature of Surve	yor:				Date:	
State Agency	1	TL/mn	n	11	/25/20	15		2720	00			11/1	0/2015
Reviewed By		Reviewed B	Зу	Da	te:	Signa	ature of Surve	yor:				Date:	
CMS RO													
Followup to	Survey Compl	eted on:					Check for any	Uncorrected	Defic	iencies. Was	a Summary of	-	
	9/21/	/2015					Uncorrecte	d Deficiencies	s (CN	IS-2567) Sent	to the Facility?	YES	NO



Electronically delivered December 2, 2015

Ms. Julie Spiers, Administrator The Margaret S Parmly Residence 28210 Old Towne Road Chisago City, Minnesota 55013

Re: Reinspection Results - Project Number S5328023

Dear Ms. Spiers:

On November 18, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 17, 2015, with orders received by you on October 5, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

#### 

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

Y4) Item	(Y	5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5) E	Date
		Correction			Correction				Correction
ID Prefix	20565	Completed 10/15/2015	ID Prefix	20570	Completed 10/15/2015		ID Prefix	20625	Completed 10/15/2015
	MN Rule 4658.0405 Subp			MN Rule 4658.0405 Subp.	=			MN Rule 4658.0450 Subp.	=
LSC			LSC	The rate 4000.0400 Gusp.			LSC	The real resolution cusp.	-
		Correction			Correction				Correction
ID Prefix	20830	Completed 10/15/2015	ID Prefix	20905	Completed <b>10/15/2015</b>		ID Prefix	20910	Completed <b>10/15/2015</b>
Reg.#	MN Rule 4658.0520 Subp	 . 1	Reg. #	MN Rule 4658.0525 Subp.	4		Reg. #	MN Rule 4658.0525 Subp.	– 5 A.I
LSC	-	<u> </u>	LSC	-	-		LSC		- 
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix	21015	10/16/2015	ID Prefix	21665	10/16/2015		ID Prefix		_
•	MN Rule 4658.0610 Subp	<del>_</del>		MN Rule 4658.1400	-		Reg. #		_
LSC		_	LSC				LSC		
		Correction			Correction				Correction
ID D . C		Completed	10 D 6		Completed		10.0.5		Completed
ID Prefix		_	ID Prefix		-		ID Prefix		-
Reg. # LSC		_ _	Reg. # LSC		-		Reg. # LSC		- -
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		_	ID Prefix		-		ID Prefix		_
Reg. # LSC		_	Reg. #				Reg. # LSC		-
		_	LSC				LSC		-
Reviewed By		-	Date:	Signature of Surve	•	22		Date:	0.4003.5
State Agency			11/25/20		312	23		11/1	8/2015
Reviewed By CMS RO	Reviewed	ІВу	Date:	Signature of Surve	yor:			Date:	
Followup to Survey Completed on: 9/17/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?  YES NO					NO		
STATE FORM		(5/99)	1	Page 1 of 1				Event ID: 7NE512	

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: ZNE5

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

	PART I	- TO BE COMP	PLETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00065
MEDICARE/MEDICAID PROVIDER I     (L1) 245328      S.TATE VENDOR OR MEDICAID NO.     (L2) 427240400	NO.	3. NAME AND AI (L3) THE MARG (L4) 28210 OLD ( (L5) CHISAGO (	GARET S PARM TOWNE ROAL	ALY RESI	DENCE (L6) 55013	4. TYPE OF ACTION: 2 (L8)  1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SU	JPPLIER CATEGO	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other  8. Full Survey After Complaint
6. DATE OF SURVEY <b>09/17/2</b> 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 DATE: (L35)  09/30
11. LTC PERIOD OF CERTIFICATION  From (a):  To (b):  12.Total Facility Beds  13.Total Certified Beds	101 (L18) 101 (L17)	Compliar1.  X B. Not in Co		gram	And/Or Approved Waivers Of T  2. Technical Personnel  3. 24 Hour RN  4. 7-Day RN (Rural SN  5. Life Safety Code  * Code: B	6. Scope of Services Limit7. Medical Director
14. LTC CERTIFIED BED BREAKDOW! 18 SNF 18/19 SNF	N 19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARK	KS (IF APPLICABL	E SHOW LTC CANC	ELLATION DATE	E):		
17. SURVEYOR SIGNATURE  Rebecca Wong, HFE N	E II	Date :	10/30/2015	(L19)	18. STATE SURVEY AGENCY  Shellae Dietrich, Ce	APPROVAL Date:  rtification Specialist 11/12/2015 (L20)
PA	RT II - TO BI	E COMPLETED	BY HCFA RI	EGIONA	L OFFICE OR SINGLE ST	
DETERMINATION OF ELIGIBILITY			MPLIANCE WITH IGHTS ACT:	CIVIL		uncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e:
22. ORIGINAL DATE  OF PARTICIPATION  07/01/1986  (L24)	23. LTC AGREEM BEGINNING (L41)		24. LTC AGREEM ENDING DAT (L25)		26. TERMINATION ACTION:  VOLUNTARY0 01-Merger, Closure 02-Dissatisfaction W/ Reimbursen	05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: (L27)	27. ALTERNATI  A. Suspension  B. Rescind Sus	n of Admissions:	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE:	20	D. INTERMEDIARY/	(L45)		30. REMARKS	
	2)	03001				
	(L28)	03001		(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL D	ATE		
	(L32)			(L33)	DETERMINATION APPI	ROVAL



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 5, 2015

Ms. Julie Spiers, Administrator The Margaret S Parmly Residence 28210 Old Towne Road Chisago City, Minnesota 55013

RE: Project Number S5328023

Dear Ms. Spiers:

On September 17, 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. In addition, at the time of the September 17, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number .

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. In addition, at the time of the September 17, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number that was found to be unsubstantiated.

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

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

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

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

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

#### **DEPARTMENT CONTACT**

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

Susanne Reuss, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 <u>susanne.reuss@state.mn.us</u> Telephone: (651) 201-3793

Fax: (651) 215-9697

#### 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 October 27, 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 October 27, 2015 the following remedy will be imposed:

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

#### 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 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 December 17, 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 March 17, 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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:

> Gary L. Schroeder – Interim Fire Safety Supervisor Health Care / Adult Foster Care / Corrections Minnesota State Fire Marshal Division

445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145 gary.schroeder@state.mn.us Office/Cell: 507-361-6204

Fax: 507-282-7899

Feel free to contact me if you have questions.

Sincerely,

Kamala Riske. Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 10/30/2015 FORM APPROVED OMB NO. 0938-0391

	N OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	FIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		245328	B. WING		09	/17/2015	
	PROVIDER OR SUPPLIER	RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT	ΓS of correction (POC) will serve	F O	00			
	as your allegation of Department's acceptor enrolled in ePOC, yat the bottom of the	of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will					
F 278 SS=D	on-site revisit of you validate that substate regulations has been your verification. 483.20(g) - (j) ASSI	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with ESSMENT	F 2	78		10/15/15	
	The assessment m resident's status.	ust accurately reflect the					
	A registered nurse each assessment v participation of hea						
	A registered nurse assessment is com	must sign and certify that the pleted.					
		o completes a portion of the sign and certify the accuracy of assessment.					
	willfully and knowin false statement in a subject to a civil mo \$1,000 for each ass willfully and knowin	d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a					
ABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE	

**Electronically Signed** 

10/15/2015

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245328	B. WING			09/1	17/2015
	PROVIDER OR SUPPLIER	RESIDENCE		28	TREET ADDRESS, CITY, STATE, ZIP CODE B210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
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F 278	Continued From paresident assessment penalty of not more assessment.  Clinical disagreem material and false  This REQUIREME by: Based on observareview, the facility in Data Set (MDS) waresidents (R88) review, the facility in Data Set (MDS) ware sidents (R88) review, the facility in Data Set (MDS) ware sidents (R88) review, the facility in Data Set (MDS) ware sidents (R88) review, the facility in Data Set (MDS) ware sidents (R88) review in July 15 and 10 don't have parent and 1 don't have parent and 1 don't have parent and 1 don't have entire mouth when	age 1 ent is subject to a civil money e than \$5,000 for each ent does not constitute a statement.  NT is not met as evidenced tion, interview and document failed to ensure the Minimum as coded accurately for 1 of 3 viewed for dental concerns.  4 p.m. when asked if she had her teeth, dentures or gums have teeth but they don't hurt	F 2	278		the ts e plan ect the one he CP ,s dified eflect fected ent	
	asked how she had she smiled. When stated staff had us	a.m. when approached and d slept R88 stated not good as asked about oral cares R88 ed some mouth wash.			resident is accurately reflected in the of care, nursing assessment and M Those noted to be incorrect will be updated and modifications to MDS completed.	e plan DS.	
	the potential for ora related to broken to two full teeth on the set up and reliance	ted 5/5/14, indicated R88 had al/dental health problems eeth on lower jaw and had only e lower jaw and R88 needed e on staff for oral hygiene.			The measures put into place to ens that the aforementioned deficient pr does not reoccur include; 1) the nur staff will review and sign all oral hea assessment forms to ensure accurainformation is updated and reflected	actice sing alth ate	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245328	B. WING		<del></del>	09/1	17/2015
	PROVIDER OR SUPPLIER	RESIDENCE		28	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
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F 278	concerns which inc or loosely fitting full teeth or tooth fragm obvious cavity or lobleeding gums, mo or difficulty with che annual MDS dated of the above preser.  Review of documer-Apple Tree Dental Assessment Form had obvious or likel teeth, had root tips, staff assistance with pain at the time of a-Apple Tree Chart Frevealed R88 had on the Assessment (CAA) completed on 7/25/ R88 diagnoses included in addition, the dem Assessment (CAA) completed on 7/25/ R88 diagnoses included in addition, muscle weak walking and unspect MD (medical doctors sheet dated 9/9/15.  On 9/16/15, at 8:57 stated R88 ate ever first once to be servant 9:07 a.m. when was breakfast R88	left blank of any dental luded but not limited to broken or partial denture, no natural lents, abnormal mouth tissue, ose natural teeth, inflamed or buth or facial pain, discomfort lewing. During further review of 7/16/15, it was revealed "None of the option had been checked."  Its revealed the following:  MDS 3.0 Oral/Dental leated 6/10/15, indicated R88 by cavity or broken natural missing teeth, required direct oral cares and had denied assessment.  Progress Notes dated 8/27/15, one intact tooth.  Ital section Care Area did not trigger for CAA 15.  Juded hemiplegia affected due cerebrovascular disease kness generalized, difficulty bified cataract obtained from hy/Nursing Communications  a.m. registered nurse (RN)-E by early and was among the red about 7:45 a.m. approached and asked how stated "It was good" when by discomfort or pain when	F 2	278	the plan of care and the NAR sheethe nurses will ensure oral health screenings are accurately reflected each nursing assessment and MDS completed going forward. Educatibeen provided to the nursing staff performing nursing assessments opolicy, ¿Resident Examination and Assessment; to ensure accurate assessment, documentation and M coding of resident oral health. All streceived education on October 6th 7th on regulation and standards of practice. Observational audits in conjunction with chart audits will be conducted for each resident, then went two dental day visits and finally quarterly to ensure compliance with regulation.  The Quality Assurance Performance Improvement (QAPI) committee with determine if discontinuation of audicindicated once practice has been doto be sustained and compliant.  Responsible Person:  Director of Nursing or Designee	with S on has on the DS raff and with the y on the le li ts is	

	OF DEFICIENCIES OF CORRECTION				(X3) DATE SURVEY COMPLETED	
		245328	B. WING		- 09	/17/2015
	PROVIDER OR SUPPLIER	RESIDENCE		STREET ADDRESS, CITY, STAT 28210 OLD TOWNE ROAD CHISAGO CITY, MN 550	TE, ZIP CODE	,20.0
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F 278	On 9/16/15, at 10:5 (NA)-G stated she morning cares and up to brush her tee told her she only wand she was able to R88 was able to ve When asked if she mouth NA-G stated surveyor about that On 9/16/15, at 1:03 surveyor stated she had only one tooth On 9/17/15, at 9:10 (DON) reviewed the and verified MDS h DON indicated a m completed for the sverified dental/oral not accurate. DON expected the MDS of current resident of current resident of current resident was was not accurated assessment which the dental issues the have been reflected RN-D acknowledge entered in the annuhave triggered. RN-coordinator who was completed the MDS the facility during the	5 a.m. nursing assistant had assisted R88 with all her for oral cares she had set her th but R88 had declined and ould rinse with mouth wash o swish twice. NA-G indicated rbalize her needs and cares. knew if R88 had teeth in her she would get back to p.m. NA-G approached had checked and found R88 in her mouth on the lower jaw.  a.m. the director of nursing annual MDS dated 7/16/15, ad not been coded accurately. odification had been ame MDS upon opening it she section was the same and was stated she would have to be accurate and reflective oral/dental status.  a.m. RN-D who also was an erified and acknowledged the rate and indicate with the had been completed 6/10/15, at had been identified should in the MDS a month later. It is difficultied that information had been that MDS the dental CAA would be further stated another MDS as working on-call basis had sat that time and was not at	F 2	278		

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245328	B. WING		09/	17/2015
	ROVIDER OR SUPPLIER	RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 278	version 3.0 dated ladental status must be of the following crites. "Check L0200 A, bropartial denture: if the cracked, uncleanable coded as loose if the loose, the denture were sident opens his comoves when the resident loose of lacks teeth.  • Check L0200 B, not fragment(s) (edentuted edentulous or lacks teeth.  • Check L0200 C, as masses, oral lesion or oral lesion is noted.  • Check L0200 D, obroken natural teeth is seen.  • Check L0200 E, in loose natural teeth: swollen, or bleeding they readily move with a fingertip."  483.20(d)(3), 483.1 PARTICIPATE PLA.  The resident has the incompetent or other incapacitated under participate in plannic changes in care and A comprehensive calculation.	ent Instrument User's Manual ast revised on October 2014, be coded on the MDS when all beria are met: roken or loosely fitting full or e denture or partial is chipped ale, or loose. A denture is e resident complains that it is visibly moves when the for her mouth, or the denture sident tries to talk.  To natural teeth or tooth allous): if the resident is all natural teeth or parts of bnormal mouth tissue (ulcers, s): Select if any ulcer, mass, and on any oral surface. bvious or likely cavity or if any cavity or broken tooth aflamed or bleeding gums or if gums appear irritated, red, g. Teeth are coded as loose if when light pressure is applied to (k)(2) RIGHT TO NNING CARE-REVISE CP eright, unless adjudged erwise found to be the laws of the State, to ng care and treatment or	F 2			10/15/15
	os.nprononoro doo	station, propared by an				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245328	B. WING		<del></del>	09/1	17/2015
	PROVIDER OR SUPPLIER	RESIDENCE		28	REET ADDRESS, CITY, STATE, ZIP CODE 210 OLD TOWNE ROAD HISAGO CITY, MN 55013		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	physician, a register for the resident, and disciplines as determed, to the extent puther resident, the relegal representative.	age 5 am, that includes the attending ered nurse with responsibility of other appropriate staff in rmined by the resident's needs, practicable, the participation of sident's family or the resident's e; and periodically reviewed eam of qualified persons after	F 2	280			
	by: Based on observareview, facility faile falls for 1 of 4 residuccidents.  Findings include: On 9/14/15, at 5:01 sitting in a wheelch half-moon shaped both eyes, had a laforehead and left at On 9/16/15, at 2:00 was interviewed ar prevent R21 from f [R21] a lot, provide her. [R21] likes to sworking with [R21]. She does try to state on 9/17/15, at 7:48	tion, interview and document d to update the care plan after dent (R21) reviewed for  I p.m. R21 was observed pair in the dining room. R21 had faint green blue bruising under accration in the middle of arm was noted to be in a sling.  I p.m. nursing assistant (NA)-I and when asked what she did to alling NA-I stated "I talk to a distractions, spend time with stack things. Therapy is a.m. was interviewed and the passible I must have fallen."			In relation to the Right to Participat Planning Care/Revise CP, it is the positive of the facility that reads, ¿Assessm residents are ongoing and care plan revised as information about the read the resident; s condition change.  For R21, the care plan has been up to reflect the current level of care not for this resident. The care plan has updated to reflect fall prevention interventions and a bowel and blade program was implemented to promurinary and bowel continence.  To ensure other residents are not a by the deficient practice, incident/accidents will be reviewed daily IDT stand-up meeting. The interventions will be reviewed and oplans updated to ensure compliance.	ents of ents are sident lee. ¿  odated eeded been der ote  ffected at our care e.	
	prevent R21 from f [R21] a lot, provide her. [R21] likes to s working with [R21]. She does try to sta  On 9/17/15, at 7:48	falling NA-I stated "I talk to distractions, spend time with stack things. Therapy is . Walking would benefit her. nd up on her own."			by the deficient practice, incident/accidents will be reviewed daily IDT stand-up meeting. The interventions will be reviewed and of	at our care e. cy, an	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245328	B. WING			09/1	17/2015
NAME OF F	PROVIDER OR SUPPLIER		ı		STREET ADDRESS, CITY, STATE, ZIP CODE		.,
THE MAI	RGARET S PARMLY F	ESIDENCE			28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	potential for injury (physical mobility, comedication use. The included adjust bed socks, assist of for assistive devices as precautions PRN, to call light within reachelp and not to be leading to the light within reachelp and not to be leading to the left forearm. In the falls were as foreight to the left forearm. In the falls were, to the left forearm to the left forearm of the left forearm. In the falls were, to monitoring to establish bowel and bladder platferent wheelchair were done. R21 did labs had been compared to be facility did not developed individualized prografter the fall.	ed 8/18/15, indicated R21 had falls) related to impaired ognitive impairment, e care plan interventions to appropriate height, gripper all transfers/ ambulation, seneded (PRN), fall ransfer belt with all transfers, h, remind every shift to call for eft unattended in bathroom.  The was reviewed and the had fallen on 8/23/15, and the Event though interventions of following each of the falls of ficant injuries R21's care planted to reflect the interventions. Illows:  Review Document Resident and 8/23/15, indicated, R21 and floor of the dining room and an tear on the left index finger of (cm) long by 4 cm deep gash. The report indicated tions implemented to prevent to continue bowel and bladder lish patterns to develop a condition of the dining room and and labs for baseline status receive a new w/c and the coleted. Even though R21 was toileted every two hours, the lop and implement an am for bowel and bladder	F 2	280	,	will be Nursing	
	Incident Report date	Review Document Resident ed 8/29/15, indicated, NA the floor in the day room. No					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		` '	E SURVEY PLETED
		245328	B. WING			09/	17/2015
	PROVIDER OR SUPPLIER	RESIDENCE		STREET ADDRESS, CITY, STATE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 5501			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD TO THE APPROPE	BE	(X5) COMPLETION DATE
F 280	implemented were, (PT) and occupation wheelchair position or doctor was to revelevation. The med had checked the blureceived PT/OT, thureflect the therapies -Confidential Peer Incident Report dat witnessed bending Martha's dining roothe head. R21 had and large bump to report interventions assess R21 for a tilfor vision field cut a R21 on safety and with R21 on balanc R21 received OT, the analysis of the plan of care.  R21's diagnoses in hypertension, other retinal degeneration obtained from the analysis (MDS) dated 8/25/1 R21 was severely or required assistance (ADL). In addition the fallen since admiss and had a fracture months prior to admission of the since admission and had a fracture months prior to admission or documents.	e report indicated interventions to continue physical therapy nal therapy (OT) to address ing and the nurse practitioner view blood pressure's due to ical review noted the physician ood pressures. Although, R21 e care plan was not revised to it.  Review Document Resident ed 9/6/15, indicated, R21 was over reaching to the floor in m and fell to the floor hitting sustained a 3 cm laceration forehead with bruising. The implemented were for OT to to in space wheelchair, assess and to continue to work with PT was to continue to work e and strengthening. Although the medical record was void of arding the assessment of the dispace w/c was not added to cluded dementia, fracture, lumbago, peripheral and difficulty walking demission Minimum Data Set 5. The MDS also indicated cognitively impaired and with activities of daily living the MDS indicated R21 had in or the prior assessment related to a fall in the six	F 2	80			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		245328	B. WING _		09/1	17/2015
	PROVIDER OR SUPPLIER	RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282 SS=D	team (IDT). RN-C i had been done and to be updated. RN-not been updated wadmission and ever two significant injur facility.  Care Plans-Comprodotober 2010 direct "An individualized dincludes measurab meet the resident's psychological need resident " In additional and the services provided by the services provided by accordance with eacare.  This REQUIREMED by:  Based on observative review, facility failed eating and reposition and services provided by:	iewed by the interdisciplinary indicated after a progress note of the care plan was supposed. C verified the care plan had with new fall interventions since in though R21 had sustained ites since admission at the ehensive policy revised ted staff: comprehensive care plan that the objectives and timetables to medical, nursing, mental and is is developed for each dition the policy indicated: of residents are ongoing and sed as information about the change"	F 28		ility¿s r of	10/15/15
	<b>9</b>			In relation to R16, a VA was filed w	vith	

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` '	X3) DATE SURVEY COMPLETED	
		245328	B. WING			<b>09</b> /1	17/2015	
	PROVIDER OR SUPPLIER RGARET S PARMLY F	RESIDENCE		2	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD CHISAGO CITY, MN 55013			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 282	Eating: During continuous 8:23 a.m. to 8:37 aAt 8:23 a.m. R16 v of the bed elevated was covering R16's it. R16 brought a sp spilling half (1/2) of stated "I can't feed -At 8:28 a.m. nursin overheard informing lunch, you feed you -At 8:37 a.m. R16 h of milk and red juic cup to mouth very schest was observed of oatmeal on the w chest. When appro "I ask for help and to During continuous of 7:20 a.m. until 11:0 -At 7:20 a.m. R16 w front of over the be waiting for breakfas -At 7:58 a.m. Break cartAt 8:06 a.m. R16 s front of resident. Br deliveredAt 8:28 a.m. NA-A -At 8:29 a.m. R16 w please help me with will come back and after I pass the resi else up." R16 sat in foodAt 8:34 a.m. all roc -At 8:34 a.m. all roc	observation on 9/15/15, from the land to 45 degrees. A white cloth is chest with oatmeal spilled on coonful of oatmeal to mouth the teaspoon on chest. R16 myself I spill everything." In a sasistant (NA)-B was g R16, "Hospice feeds you for inself breakfast." In ad a covered cup with a spout the on tray. R16 was able to lift slowly. At the same time R16's d with one third of R16's bowly white cloth that covered the ached R16 stated to surveyor, they say they are too busy."  Observation on 9/16/15, from 0 a.m. were as follows: was still seated in wheelchair in d table. R16 stated was	F 2	282	OHFC and an investigation was conducted. The staff members wor with R16 were educated on Reside Rights and the resident; s need for assistance with feeding and reposit The resident; s plan of care was re of R16; s current needs. The syste passing trays on the station has be modified to ensure R16; s tray is deper R16; s preferred time and assis staff with eating. Additionally, R16, preference for where R16 eats in rehas been determined and the plan has been updated to reflect this preference.  The facility will identify residents potentially affected by the deficient practice by auditing residents receiroom trays to ensure the plan of cabeing followed along with noted preferences for dining. Furthermore residents at risk for skin breakdown on repositioning programs will be a for compliance.  To ensure the deficient practice docrecur all staff were re-educated on October 6th and 7th related to CP compliance, resident choice, preve skin breakdown and passing of me trays. The NAR sheets have been updated to reflect the date last upd The NAR sheets will be signed by the NAR caring for each group and return to the nurse manager after every should be signed by the number of the nurse manager after every should be signed by the number of the nurse manager after every should be signed by the number of the nurse manager after every should be signed by the number of the nurse manager after every should be signed by the number of the nurse manager after every should be signed by the number of the nurse manager after every should be signed by the number of the nurse manager after every should be signed by the number of the nurse manager after every should be signed by the number of the nurse manager after every should be signed by the number of the	iconing. flective m of en elivered sted by s s com of care  ving re is e, n and udited  es not  ated. he urned nift. be x4,		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245328	B. WING			09/-	17/2015
	PROVIDER OR SUPPLIER	RESIDENCE		2	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	R16 stated, "It was sitting here for over it. I asked for help t back. It is so hard a when I do that."  -At 8:55 a.m. regist tray from room. R1c cereal and had druid R16's nutritional statement of trays and feeding a R16's activities of devised 8/7/15, include but (difficulty swallowind disease (stroke), midented (difficulty swallowind disease (stroke), midented (sheet for R16 indicated) Undated/unlabeled sheet for R16 indicated (sheet for R16 indicated) On 9/16/15, at 9:32 said, R16 needed in help today and I tole busy."  On 9/16/15, at 11:0 asks for assistance sit there." [R16] chook with understand have to do feed here	good once I got it. I have been an hour before they brought o eat, but she never came and I spill on myself. I hate it ered nurse (RN)-B removed had eaten 100 percent of hot had eaten 100 percent of hot had a quarter of cup of milk.  Attus care plan revised on resident is requesting room ssist most meals."  Attusing (ADLs) care plan cated, "The resident requires be of 1 staff to eat."  from Admission Record dated that not limited to dysphagia goldue to cerebrovascular uscle weakness, major and anxiety.  Nursing Assistant Assignment ated, "Assist of 1 for all ADLs."  a.m. nursing assistant (NA)-A help eating. "[R16] asked for dother I will back, but I was too to so a.m. RN-B stated "If [R16] they are to help her or at least boses to eat in room. [R16] is ing, if eats in room, [R16] may reelf. People who need	F 2	282	timely, plan of care is followed and sheets are signed and turned into the nurse manager. In addition, turning repositioning audits will be completed aily x 2 weeks, then weekly x4, armonthly.  The Quality Assurance Performance Improvement (QAPI) will determined discontinuation of audits is indicated current practice has been deemed sustained and compliant.  Completion Date: October 15, 2019.  Person(s) Responsible: Director of Nursing Executive Administrator.	the g and ted nd then ce e if ed once	
	On 9/16/15, at 11:0 asks for assistance sit there." [R16] cho ok with understandinave to do feed her assistance are in the with [R16], some data	they are to help her or at least poses to eat in room. [R16] is ing, if eats in room, [R16] may					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		245328	B. WING		09	/17/2015
	PROVIDER OR SUPPLIER	RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CO 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
(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 A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	We may need to redining room if [R16 to be passed within On 9/17/15, at 11:2 (DON) stated, "My resident asks for he tremor and may ne Sometimes she ne do it herself." She rextensive assistant not have to ask for this." When asked the assistance and replied, "No. I will be report on this." Policy for providing requested from fact Repositioning: During continuous 7:08 a.m. until 11:0-7:08 a.m. R16 sitti-7:50 a.m. R16 sitti-8:28 a.m. NA-A todid not reposition F-8:55 a.m. registere tray. RN-B did not resident in the sitti-9:09 a.m. R16 who bed9:15 a.m. RN-A talesida a.m. RN-A t	espice aide to feed her lunch. Evisit with [R16] eating in the original problem in the original problem. Trays are in 15 minutes.  If a.m. director of nursing expectation is anytime a pelp you help them. She has a red help. It is on and off, eds help sometimes she can require per care plan or compared to eat. "She should assistance to eat based on if your staff providing her with cares she needs. DON re filing a vulnerable adult assistance with eating was illity but not provided.  Observation on 9/16/15, from 0 a.m. in wheelchair getting her hair ing in wheel chair.  Ing waiting for breakfast. Ok tray in to R16 room. NA-A R16. Oct and the compared to the compare	F 2	82		
		ng in wheelchair with her eyes a cushion in the wheelchair				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		245328	B. WING		09	/17/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		, , , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 282	Continued From p	•	F 2	82			
	did not shift buttoot -10:13 a.m. R16 sinot changed positi -10:53 a.m. the beroom11:00 a.m. R16's assistance of NA-0 chair to toilet. Botto cocyx to peri area approximately five side of center. No The area did not a incontinent product when NA pressed stated, "This is reconstructed."  Pressure ulcer care 4/27/15, indicated break down r/t [relivaried oral intakes mobility."  Diagnosis for R16 9/16/15, include bueffects of cerebrow	itting under the drier. R16 had					
	with potential for fa DJD [degenerative m/b [manifested/b] wheel self, turn/rep indicated "Turn an	r "decreased physical mobility alls and impaired skin r/t dx of e joint disease], chronic pain y] inability to transfer, ambulate, position" printed on 9/16/15, d reposition resident every 2 s needed] using pillows."					
		d "nursing assistant assignment icated, "Reposition Q[every] 2H					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245328	B. WING		·····	09/ <sup>-</sup>	17/2015	
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD CHISAGO CITY, MN 55013			
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	OULD BE COMPLETION		
F 282	resident frequently On 9/16/15, at 10:2 "[R16] gets her hai every week. The ai residents unless I o problem. I come ar them back." On 9/16/15, at 10:5 not usually get out when needed help every two hours. On 9/16/15, at 11:0 skin was red but bl blanchable pressur infection that we ar and more absorber expectation for rep pressure ulcer eve offer every two hou  On 9/17/15, at 11:2 expectation was [F just did this enorm and pressure ulcer asked [R16] to offlo would be at risk for we have alternating w/c but [R16] still in asked are your sta assistance and car replied,"No. I will b report on this."	and "turn and Reposition" AT LEAST Q2H."  23 a.m. beautician stated, or done weekly at the same time des do not check on the call them and say there is a red get the residents and bring  26 a.m. RN-B stated, R16 did of bed. R16 was able to tell us and and say there is a red get the residents and bring  25 a.m. RN-B stated, [R16's] anchable there are no non re areas. She has a fungal re treating with Nystatin cream in the brief. RN-B stated "my ositioning is if there is a current rey one hour, otherwise at least are."  23 a.m. the DON stated, "the cous education on repositioning prevention. We could have be odd and offered to help. [R16] is pressure ulcers, that is why go air mattress and cushion in reeds to be off loaded." When a figure of the red in the resident in the resident and the resident in	F 2					
F 312 SS=D	483.25(a)(3) ADL ( DEPENDENT RES	CARE PROVIDED FOR SIDENTS	F3	112			10/15/15	

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
	245328	B. WING		09/-	17/2015	
NAME OF PROVIDER OR SUPPLIER  THE MARGARET S PARMLY RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CO 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
A resident who is a daily living received maintain good nutrand oral hygiene.	inable to carry out activities of s the necessary services to ition, grooming, and personal	F 3	12			
by: Based on observareview, failed to proper for 1 of 1 resident hospice.  Findings include: R16 was observed did not receive the breakfast.  During continuous 8:23 a.m. to 8:37 a-At 8:23 a.m. R16 of the bed elevated was covering R16' it. R16 brought a significant feed and the specific feed you breakfast."  -At 8:28 a.m. NA-E "Hospice feeds you breakfast."  -At 8:37 a.m. R16 of milk and red juic cup to mouth very chest was observed.	on 9/15/15, and 9/16/15, and requested assistance to eat observation on 9/15/15, from the assistance to eat observation on 9/15/15, from 15/15/15, from 15/15/1		Dependent Residents, it is the facility to provide necess residents who are unable to activities of daily living in an maintain good nutrition, groupersonal and oral hygiene.  In relation to R16, a VA was OHFC and an investigation of conducted. The staff member with R16 were educated on Rights and the resident; since assistance with feeding and The resident; sight plan of care of R16; sight current needs. The passing trays on the station modified to ensure R16; sight per R16; sight preference for where R16 each has been determined and the has been determined and the has been updated to reflect preference.  The facility will identify reside potentially affected by the determined and the determined and the determined and the potentially affected by the determined by the determined and the determined an	ne policy of eary service to carry out effort to oming and filed with was ers working Resident; seed for repositioning, was reflective e system of has been ay is delivered at assisted by y, R16; sets in room e plan of care this		
)	SUMMARY STA (EACH DEFICIENCE REGULATORY OR IS (EACH DEFICIENCE MAINTAIN AND IS UDAINED AND IS U	PROVIDER OR SUPPLIER  RGARET S PARMLY RESIDENCE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 14  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, failed to provide assistance with eating for 1 of 1 resident (R16) who was reviewed for hospice.  Findings include:  R16 was observed on 9/15/15, and 9/16/15, and did not receive the requested assistance to eat breakfast.  During continuous observation on 9/15/15, from 8:23 a.m. to 8:37 a.m. were as follows: -At 8:23 a.m. R16 was lying in bed with the head of the bed elevated to 45 degrees. A white cloth was covering R16's chest with oatmeal spilled on it. R16 brought a spoonful of oatmeal to mouth spilling half (1/2) of the teaspoon on chest. R16 stated "I can't feed myself I spill everything." -At 8:28 a.m. NA-B was overheard informing R16, "Hospice feeds you for lunch, you feed yourself	PROVIDER OR SUPPLIER  RGARET S PARMLY RESIDENCE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 14  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, failed to provide assistance with eating for 1 of 1 resident (R16) who was reviewed for hospice.  Findings include:  R16 was observed on 9/15/15, and 9/16/15, and did not receive the requested assistance to eat breakfast.  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When approached R16 stated to surveyor,	PROVIDER OR SUPPLIER  REGARET S PARMLY RESIDENCE  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 14  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by:  Based on observation, interview, and document review, failed to provide assistance with eating for 1 of 1 resident (R16) who was reviewed for hospice.  R16 was observed on 9/15/15, and 9/16/15, and did not receive the requested assistance to eat breakfast.  During continuous observation on 9/15/15, from 8.23 a.m. to 8.37 a.m. were as follows:  -At 8.23 a.m. R16 was lying in bed with the head of the bed elevated to 45 degrees. A white cloth was covering R16's chest with oatmeal spilled on it. R16 brought a spoonful of oatmeal to mouth spilling half (1/2) of the teaspoon on chest. R16 stated "I can't feed myself I spill everything."  -At 8.23 a.m. R16 had a covered cup with a spout of milk and red juice on tray. R16 was able to lift cup to mouth very slowly. At the same time R16's chest was observed with one third of R16's bowl of oatmeal to the white cloth that covered the chest. When approached R16 stated to surveyor,	PROVIDER OR SUPPLIER  ROARET S PARMLY RESIDENCE  SUMMARY STATEMENT OF DEFICIENCIES (EACH OBERCIVE AND THE SPECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 14  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by:  Based on observation, interview, and document review, failed to provide assistance with eating for 1 of 1 resident (R16) who was reviewed for hospice.  Findings include:  Findings include:  Findings include:  During continuous observation on 9/15/15, from 8:23 a.m. to 8:37 a.m. were as follows:  -At 8:23 a.m. R16 was lying in bed with the head of the bed elevated to 45 degrees. A white cloth was covering R16's chest with oatmeal spilled on it. R16 brought a spoonful of oatmeal to mouth spilling half (1/2) of the teaspoon on chest. R16 stated '1 carl' teed myself 1 spill everything.''  -At 8:28 a.m. NA-B was overheard informing R16, 'Hospice feeds you for lunch, you feed yourself breakfast.''  -At 8:23 a.m. NA-B was overheard informing R16, 'Hospice feeds you for lunch, you feed yourself breakfast.''  -At 8:23 a.m. 16 had a covered cup with a spout of milk and red juice on tray, R16 was able to lift cup to mouth very slowly. At the same time R16's chest was observed with one third of R16's bowl of oatmeal on the white cloth that covered the chest. When approached R16's stated to surveyor, state of the deficient potentially will identify residents potentially affected by the deficient practice by auditing residents receiving page 1.0 may	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				DATE SURVEY COMPLETED	
		245328	B. WING		<del> </del>	09/1	7/2015	
NAME OF PROVIDER OR SUPPLIER  THE MARGARET S PARMLY RESIDENCE				28	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD CHISAGO CITY, MN 55013			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 312	7:20 a.m. until 11:0 -At 7:20 a.m. R16 of front of over the bewaiting for breakfa -At 7:58 a.m. Break cartAt 8:06 a.m. R16 of front of resident. BedeliveredAt 8:28 a.m. NA-A-A-A-A-A-A-A-A-A-A-A-A-A-A-A-A-A-A-	observation on 9/16/15, from 20 a.m. were as follows: was still seated in wheelchair in ed table. R16 stated was st.  kfast trays arrived in unit on sitting in room, tray table in reakfast tray had not been a took tray in to R16's room. Was heard ask NA-A, "can you he breakfast?" NA-A replied, "I delip you if I have the time at of the trays and get someone in front of the table with the tray om trays had been passed. In asked how was breakfast? I good once I got it. I have been or an hour before they brought to eat, but she never came and I spill on myself. I hate it tered nurse (RN)-B removed 6 had eaten 100 percent of hot ank a quarter of cup of milk.  Sessment (CAA) dated 4/22/15, and most meals in her room and the feeding."	F3	312	being followed along with noted preferences for dining. Furthermore residents at risk for skin breakdown on repositioning programs will be a for compliance.  To ensure the deficient practice do recur all staff were re-educated on October 6th and 7th related to CP compliance, resident choice, preve skin breakdown and passing of me trays. The NAR sheets have been updated to reflect the date last upd The NAR sheets will be signed by the NAR caring for each group and retute to the nurse manager after every slobservational and chart audits will conducted daily x 2 weeks, weekly then monthly to ensure trays are detimely, plan of care is followed and sheets are signed and turned into the nurse manager. In addition, turning repositioning audits will be completed aily x 2 weeks, then weekly x4, and monthly.  The Quality Assurance Performance Improvement (QAPI) will determined discontinuation of audits is indicate current practice has been deemed sustained and compliant.  Person(s) Responsible: Director of Nursing and Executive Administrate Designee	n and udited es not ntion of al ated. the urned hift. be x4, elivered NAR he g and ed nd then ee if d once		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	,		` '	E SURVEY PLETED	
		245328	B. WING			09/	17/2015	
NAME OF PROVIDER OR SUPPLIER  THE MARGARET S PARMLY RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE  28210 OLD TOWNE ROAD  CHISAGO CITY, MN 55013					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 312	symptoms of mode Indicated R16 requieating meals.  R16's activities of drevised 8/7/15, indicextensive assistance Diagnoses for R16 9/16/15, include but (difficulty swallowing disease (stroke), mode depression, fatigue  The Weights and V 9/17/15, indicated F156.1 and on 9/11/1 had lost approximate months.  On 9/16/15, at 9:32 family made arrange come in at noon to eating. [R16] asked will back, but I was On 9/16/15, at 11:0 asks for assistance sit there." [R16] chook with understandinave to do feed her assistance are in the with [R16], some date are not so good becarranged for the howe may need to redining room if [R16] to be passed within	rate depression. The MDS fred assistance from staff with ally living (ADLs) care plan cated, "The resident requires se of 1 staff to eat."  from Admission Record dated and limited to dysphagia go due to cerebrovascular uscle weakness, major and anxiety.  itals Summary printed on R16's weight on 5/3/15, was 15, was 150.4 pounds. R16 tely 5.7 pounds in four  a.m. NA-A stated, "the ements for the hospice aide to feed [R16]. [R16] needs help for help today and I told her I too busy." 5 a.m. RN-B stated "If [R16] they are to help her or at least poses to eat in room, [R16] is ng, if eats in room, [R16] may self. People who need e dining room. It is difficult ays are good and someday's cause of [R16's] tremor. We spice aide to feed her lunch. visit with [R16] eating in the needs help eating. Trays are	F 3	12				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245328	B. WING		09/	17/2015
NAME OF PROVIDER OR SUPPLIER  THE MARGARET S PARMLY RESIDENCE			2	STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314 SS=D	resident asks for he tremor and may no Sometimes she ne do it herself." She ne extensive assistant not have to ask for this." When asked with the assistance replied, "No. I will be report on this." R16 services to maintai Policy for providing requested from fact 483.25(c) TREATM PREVENT/HEAL F.  Based on the compresident, the facility who enters the faci does not develop pindividual's clinical they were unavoidad pressure sores receives to promote prevent new sores.  This REQUIREME by:  Based on observative, the facility fassistance with report of the prevent new sores.	expectation is anytime a elp you help them. She has a eled help. It is on and off. eds help sometimes she can requires per care plan be of one to eat. "She should assistance to eat based on are your staff providing her and cares she needs? DON to filing a vulnerable adult of did not receive the care and an good nutritional status. assistance with eating was illity but not provided. IENT/SVCS TO PRESSURE SORES  Orehensive assessment of a remust ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and the healing, prevent infection and from developing.  NT is not met as evidenced tion, interview, and document ailed to provide necessary resident in the provident in the providen	F 312		the oment	10/15/15
	Findings include:			treatment and services to promote healing, prevent infection and prevent		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245328	B. WING			09/17/2015	
	PROVIDER OR SUPPLIER RGARET S PARMLY F	RESIDENCE		28	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		.,,
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROFICIENCY)		BE	(X5) COMPLETION DATE
F 314	During continuous of 7:08 a.m. until 11:0 noted: -7:08 a.m. R16 up i combed7:35 a.m. R16 sitti-7:50 a.m. R16 sitti-8:28 a.m. nursing a R16 room. NA-A did-8:55 a.m. registere tray. RN-B did not r-9:09 a.m. R16 whe bed9:15 a.m. RN-A tal-9:33 a.m. RN-A sti unchanged9:44 a.m. Beauticia shop9:54 a.m. R16 sitti closed. There was that was approximated in the sitting of the	observation on 9/16/15, from 0 a.m. and the following was in wheelchair getting her hair ing in wheel chair. Ing waiting for breakfast. It is assistant (NA)-A took tray in took of not reposition R16 and nurse (RN)-B picked up reposition R16. It is eled herself slowly toward her limit with R16 in R16's room. It in room. R16's position an took R16 to the beauty in wheelchair with her eyes a cushion in the wheelchair ately three inches thick. R16 is.	F3	314	In relation to R16, a VA reported way with OHFC and investigation fully conducted. The staff members involved were educated to follow the plan of ensure the integrity of the resident, was maintained. Staff members educated to ensure residents unable to repost off-load independently are reposition according to the plan of care to present breakdown of skin and maintain the integrity of the skin. R16 has a present alternating mattress on bed and present educing cushion in wheelchair. Resident does not have a pressure related injury to skin at this time. To NAR sheets have been updated to the date last updated and NAR; as a sign and date after each shift and resident practice, all staff were re-educated on October 6th and 7th prevention of pressure related injured to ensure the plan of care is followed. Additionally, staff will re-assess resident who are dependent on others for repositioning or off-loading and ensities factors have been assessed an interventions in place to prevent ulcerations or skin breakdown. Eduwas also provided on prevention of pressure ulcers and assessing risk factors. The nursing staff will continuously skin assessm with all new admits, quarterly and we also provided on prevention of pressure ulcers and assessing risk factors. The nursing staff will continuously skin assessm with all new admits, quarterly and we also provided on prevention of pressure ulcers and assessing risk factors. The nursing staff will continuously skin assessm with all new admits, quarterly and we also provided on prevention of pressure ulcers and assessing risk factors. The nursing staff will continuously skin assessm with all new admits, quarterly and we also provided on prevention of pressure ulcers and assessing risk factors. The nursing staff will continuously staff will continuously staff will continuously skin assessm with all new admits, quarterly and we also provided on prevention of pressure ulcers and assessing risk factors. The nursing staff will continuously and the provided provided provided provided pr	olved care to care to care to care to ducated sition or oned vent essure essure esident edule. he reflect ure to eturn n. by the n on ies and ed. idents sure and idents sure ident idents sure ident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245328	B. WING		09/17/2015
	PROVIDER OR SUPPLIER RGARET S PARMLY I	RESIDENCE	:	STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013	
(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 APPRODEFICIENCY)	D BE COMPLÉTION
F 314	break down r/t [relavaried oral intakes, mobility."  R16's quarterly Mir 7/20/15, indicated I with symptoms of r MDS indicated R16 with all activities of Diagnosis for R16 f 9/16/15, include bu effects of cerebrove muscle weakness, anxiety.  R16's care plan for with potential for fa DJD [degenerative m/b [manifested/by wheel self, turn/repindicated "Turn and hours and PRN [as The undated/unlab Assignment sheet Q(every) 2H (hour) Reposition resident Q(every) week. The air residents unless I coproblem. I come ar them back."  On 9/16/15, at 10:5 not usually get out	inted/to] friction/shear potential, advance age, and decreased imum Data Set (MDS) dated a 16 was alert and oriented noderate depression. The required assistance from staff daily living including mobility. From Admission Record dated the not limited to other late ascular disease (stroke), major depression, fatigue and "decreased physical mobility and impaired skin r/t dx of joint disease], chronic pain inability to transfer, ambulate, osition" printed on 9/16/15, a reposition resident every 2 needed] using pillows."  Teled Nursing Assistant for R16 indicated, "Reposition using pillows" and "turn and a frequently-AT LEAST Q2H."  Ta a.m. beautician stated, done weekly at the same time des do not check on the stall them and say there is a lad get the residents and bring	F 314	significant changes to determine factors and interventions.  Furthermore, the beauticians have ducated to ensure the staff are raware and signed out when they been assisted off the station to the shop. The NAR; shave been educated to residents prior to leaving station with repositioning/off-loading prevent skin breakdown. Furthermore residents at risk for skin breakdown on repositioning programs will be for compliance.  To ensure the deficient practice does recur, the NAR sheets have been to reflect the date last updated. The sheets will be signed by the NAR for each group and returned to the manager after every shift. Observand chart audits will be conducted turning and repositioning needs or residents daily x 2 weeks, weekly monthly to ensure the plan of care followed and NAR sheets are significant into the nurse manager.  The Quality Assurance Performar Improvement (QAPI) will determined into the nurse manager.  The Quality Assurance Performar Improvement (QAPI) will determined into the nurse manager.  The Pusality Assurance Performar Improvement (QAPI) will determined into the nurse manager.  The Pusality Assurance Performar Improvement (QAPI) will determined into the nurse manager.  The Pusality Assurance Performar Improvement (QAPI) will determined into the nurse manager.	e been nade have e beauty ucated to g the ng to nore, vn and audited  oes not updated he NAR caring e nurse rational d for f x4, then e is ned and  nce he if ted once d

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245328	B. WING _		09/	17/2015
	PROVIDER OR SUPPLIER	RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	skin is red but bland blanchable pressur infection that we are and more absorber expectation for reportsure ulcer ever offer every two hou.  On 9/17/15, at 11:2 (DON) stated, "The offloaded. We just to on repositioning and We could have ask to help. [R16] would that is why we have cushion in w/c but [loaded." When ask her with the assista DON replied, "No. I report on this."  Prevention Of Pres February 2014 institute "General Preventive 3. For a person in a a. Change pos	5 a.m. RN-B stated, "[R16's] chable there are no non e areas. She has a fungal e treating with Nystatin cream at brief." RN-B stated "My ositioning is if there is a current y one hour, otherwise at least rs."  3 a.m. the director of nursing expectation is [R16] has to be did this enormous education d pressure ulcer prevention. ed [R16] to offload and offered d be at risk for pressure ulcers, alternating air mattress and R16] still needs to be offed if your staff are providing nce and cares she needs. will be filing a vulnerable adult sure Ulcers procedure revised ructed staff: e Measures chair: sition at least every hour; and el or air cushion as indicated		4		
F 315 SS=D	Based on the residence assessment, the far resident who enters indwelling catheter	HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a the facility without an is not catheterized unless the condition demonstrates that	F 31	5		10/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245328	B. WING _		09/	09/17/2015	
	PROVIDER OR SUPPLIER	RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013			
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F 315	catheterization was who is incontinent treatment and serv infections and to re function as possibl	s necessary; and a resident of bladder receives appropriate ices to prevent urinary tract estore as much normal bladder	F 31	5			
	review, the facility was managed in a the pulling and tuge for 2 of 2 residents urinary incontinence.  R176 was observed being wheeled into assistant (NA)-G. At the table to adjust R176 was observed grimaced as if in payas pulling on the the W/C, lying on the tubing coiled and cowheel. The cathete bag under the W/C out and was dragg immediately, bent of W/C. NA-G was the portion of the W/C wheel and tucked the tunder the W/C. NA his table then was	tion, interview and document failed to ensure catheter tubing manner to potentially minimize ging of the inserted catherter (R176, R159) reviewed for e.  ed on 9/16/15, at 8:38 a.m. the dining room by nursing As NA-G wheeled R176 around R176's wheelchair (W/C), d to grab on his crotch, facially ain, and indicated something catheter tubing. Underneath the floor, was the catheter aught under the left front er bag was stored inside a blue of, however the tubing was left ed on the floor. NA-G stopped over and looked under the en observed to lift the front to get the tubing off the front the tubing into the blue bag and continued to wheel R176 to observed speak briefly to R176 wash hands. No blood was		In relation to No Catheter, Pre Restore Bladder, it is the policy facility to ensure catheter tubin managed in a manner that min pulling or tugging of the inserted. For R176 and R159, the tubing adjusted and the clips are being ensure the tubing is off the floor ordered additional dignity bags the drainage bag and tubing fit into the bag. In addition, fabric bags are being sewn by volunt as needed to promote dignity.  The facility will identify other rethe potential to be affected by practice by auditing all current utilizing urinary catheters to enplacement of drainage bags ar Residents will be monitored quenting ensure proper placement of ur drainage bags and tubing to protential injury to the resident. To ensure others are not affect residents admitted with or inseindwelling catheter has been reensure appropriate use. In according to the catheter was a suppropriate use.	of the g is imizes d catheter.  I has been g utilized to r. Site has to ensure properly dignity eers for use sidents with he deficient residents sure proper d tubing. hift to nary event ed, all rtion of an eviewed to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245328	B. WING			09/17/2015	
	PROVIDER OR SUPPLIER			28	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 315	been brought to the R176 was observed from the nursing state from the medication was observed lying and the tubing was wheel approximate time observed sevenever offered or actubing.  R176's diagnoses hypertrophy prostate other lower symptot tract infections and III obtained from the Communications of the lower symptot tract infections and III obtained from the Communications of the lower symptot tract infections and III obtained from the Communications of the least of the lower symptot tract infections and III obtained from the Communications of the least of	a.m. even after concern had e attention of the unit manager of seated on the W/C across fation approximately four feet on cart and the catheter tubing on the floor under the W/C exclose to the left front W/C exply three centimeters. At the eral staff walk past R176 and didressed to adjust the catheter included difficulty walking, attemed with urinary obstruction and oms, personal history of urinary of chronic kidney disease stage of MD/Nursing theet dated 8/20/15.  Intinence and indwelling a Assessment (CAA) dated a Assessment (CAA) dated a Assessment (CAA) dated a Assessment (CAA) dated a Assessment (CAA) without a R176's care plan dated a Assessment (BPH) with the retention. The care plan sition the catheter bag and evel of the bladder and away on door and check the tubing for ach shift.  Order signed but undated, for a Foley catheter 16 French	F3	315	storage of the urinary drainage tubble below the bladder and properly see and stored to prevent injury to the resident.  To monitor compliance, nursing will conduct observational audits for reutilizing indwelling urinary catheters 2 weeks, then weekly x4 weeks, arfinally monthly.  The Quality Assurance Performance Improvement (QAPI) will determine discontinuation of audits is indicate current practice has been deemed sustained and compliant.  Person(s) Responsible: Director on Nursing and Executive Administrate Designee	esidents s daily x and se if donce to be	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
		245328	B. WING _		09	/17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 315	that way and the s the extra tubing wa caught by the whe was going to check had not been injure on that morning.  On 9/16/15, at 11:4 to follow up on the had assisted R176 transferred him int thought she had tu blue bag under the was something like the tubing to make	age 23 not supposed to be positioned taff was supposed to ensure as in the bag to prevent being el. RN-E acknowledged she k R176 to make sure the penis ed as a result of being pulled  40 a.m. NA-G was interviewed observation she stated she to get ready that morning and to the wheelchair and she tacked the extra tubing into the ew/C. When asked if there exactly a clip that was used to secure a sure it does not roll out she to the work on the well you know	F 31	5		
	seated on her whe area in front of the catheter bag was of bag under the W/O approximately two observed lying on tubing was noted to entire visible length -At 1:37 p.m. active the unit as she state bring her to the dire birthday party. As a the catheter tubing floor exposed and along the length st -At 1:40 p.m. to 2:5 the dining room (D	ity staff (A)-A wheeled R159 off ted to R159 she was going to ning room for the monthly A-A wheeled R159 off the unit was noted dragging on the yellow urine was observed				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	` '	TE SURVEY MPLETED
		245328	B. WING		09	/17/2015
	PROVIDER OR SUPPLIER	RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP COI 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 315	hallway outside the R159 W/C and did  On 9/16/15, at 7:00 seated on the W/C common area. Who she was doing R15 had slept "pretty go observed all dresselying again on the fithe entire approxim catheter bag was sunderneath the W/G just hanging along -At 8:23 a.m. the how wheeled R159 off tistill lying on the floor -At 8:33 a.m. R159 DR table with the common station the catheter floor.  At 10:50 a.m. R159 out of the DR to the being dragged on ti-At 9:16 a.m. A-A with the chapel catheter floor.  At 10:50 a.m. R159 W/C in the common station the catheter visible. When stands several staff went purses and NA's not on 9/17/15, at 7:50 been brought to the 9/16/15, R159 was across from the nurse.	While observing R159 from the DR several staff went past not conceal the tubing.  It a.m. R159 was observed in front of the television in the en approached and asked how 9 stated was doing well and od." At the time R159 was do and the catheter tubing was loor with yellow urine noted on ately (2 ½) feet and the tored in the blue bag C and a plastic black clip was the length of tubing. Ealth unit coordinator (HIC) he unit with the catheter tubing or dragging along. Was seated on her W/C at the atheter tubing still lying on the atheter tubing still lying on the com.  Was observed being wheeled a unit with the catheter tubing he floor. Was observed wheel R159 into tubing still dragging on the seated on the narea across from the nursing tubing lying on the floor ding at the nursing station wast R159's W/C including one offered to store it properly.  It a.m. even after concern had a unit managers attention on observed seated on her W/C	F 31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		245328	B. WING _		09	/17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 315	lying on the floor use approached and as being exposed both respond but smiled finger through a strength of the smile of t	ander the W/C. When sked if the catheter tubing hered her R159 did not dand continued to run her suffed dog she was holding.  Included dementia without her's disease, muscle ified retention of urine, rand urinary obstruction Nursing Communication sheet Drder dated 9/9/15, revealed an atheter 16 French with 10 cubic floon.  Idated 8/31/15, identified R159 catheter related to urinary by to neurogenic bladder. The staff to position the catheter ow the level of the bladder and e room door and check the h cares each shift.	F 31	5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245328	B. WING		09/17/2015	
	PROVIDER OR SUPPLIER	RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	HOULD BE COMP	
F 371 SS=E	clip was not able to from rolling out of be report to the nurse with tubing would be On 9/17/15, at 9:06 (DON) stated the cathe floor and be unabag. DON further stat long" to preven and also thought was Both DON and adma a dignity issue as not receive the necent the catheter tubing impaired bladder furth 483.35(i) FOOD PESTORE/PREPARE.  The facility must - (1) Procure food from considered satisfact authorities; and	staff had identified the plastic secure the tubing to prevent it ag the NAs were supposed to immediately and a new bag e changed.  a.m. the director of nursing atheter tubing should be off der the chair hang and in the tated "the tubing should not be at the tubing from being caught as an infection control issue. Ininistrator acknowledged it was ot everyone needed to know a eter. Both R176 and R159 did essary care and services for placment as to avoid potential inction.  ROCURE, (SERVE - SANITARY)	F 315			10/15/15
	by: Based on observative review, the facility facility facility facility facility facility.	NT is not met as evidenced tion, interview and document ailed to follow equipment tes that would minimize the orne illness. This had the		All areas identified have been thoro cleaned. Education and training was provided to all kitchen staff. The poland procedure for cleaning schedule	s licy	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		245328	B. WING _		09/	17/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP ( 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 371	which was served Findings include:  During kitchen tour following sanitation confirmed by the disconfirmed by the four burner stous a greasy black subthe four burner stous a greasy black subthe four burner stous greasy substance sides of the door. I cleaned and stated completed on the disconfirmed burner and inches disconfirmed black/brows buildup of black/brows buildup of black/brows buildup of black/brows buildup disconfirmed burner pipe piping going to the connecting joint suddirty with heavy dusurfaces. Piping divalve to the left of	as of 87 residents in the facility, food out of the kitchen.  If on 9/14/15, at 1:00 p.m. the a concerns were observed and irector of nutrition services  Thad a heavy buildup of a black ront top aluminum piece width X 24" length), right side of th X 18" length) and on the back of the stove. The corners we top grates had a buildup of estance. The oven door below we had a buildup of a brown on and around the handle and DNS verified it needed to be dimajor oven cleaning is weekends.  kitchen tour on 9/16/15, at owing sanitation concerns were	F 37	reviewed and updated. Aucompleted daily x 2 weeks, then monthly to ensure con Quality Assurance Perform Improvement (QAPI) will dediscontinuation of audits is current practice has been a sustained and compliant.  Person(s) Responsible: Di Services or Designee	weekly x4, npliance. The ance etermine if indicated once leemed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/S IDENTIFICATI	ON NUMBED:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
24	5328 B. WIN	B. WING			09/17/2015	
NAME OF PROVIDER OR SUPPLIER  THE MARGARET S PARMLY RESIDENCE	•	STREET ADDRESS, CITY, STATE, ZIP CODE  28210 OLD TOWNE ROAD  CHISAGO CITY, MN 55013				
(X4) ID SUMMARY STATEMENT OF DEFIC PREFIX (EACH DEFICIENCY MUST BE PRECEI TAG REGULATORY OR LSC IDENTIFYING IN	DED BY FULL PRE	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE	
F 371  Continued From page 28 soiled with dirt/food debris. When buildup was scraped with a spatul stated she was not sure what the and verified it should have been of Maintenance Orders policy dated directed staff to submit a TELS (at campus wide work order system) issues related to patient safety surprecautions and to identify the issues related to patient safety surprecautions and to identify the issues the TELS request. The policy furth to call the on-call maintenance state the computers were not in working.  The facility Cleaning Instructions: Ovens dated 2010, indicated the coleaned as needed and according schedule (at least once every two policy was provided for cleaning the surrounding area.  F 456 SS=E  F 456 SS=E  OPERATING CONDITION  The facility must maintain all esses mechanical, electrical, and patient equipment in safe operating condition.  This REQUIREMENT is not met a by: Based on observation, interview, review, the facility failed to maintal a safe operating condition for 1 of (R45) reviewed for environmental those residents who received ice for machines out of the kitchen/kitchri	the debris a, the DNS substance was eaned.  Requesting 10/31/14, n online request for any ch as fall ue as Critical on her directed staff ff member if g order.  Ranges and evens will be to the cleaning weeks). No he stove top and  MENT, SAFE  Intial care tion.  As evidenced and document in equipment in if 1 resident concerns and rom the ice	F 371	The air conditioning valve in R45's was repaired. All staff has been ed to report any maintenance concern the TELs system. Education is protate each nursing station and through building on how to submit a TELs re	room lucated using vided nout the	10/16/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245328	B. WING		09/	17/2015	
	PROVIDER OR SUPPLIER RGARET S PARMLY I	RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP COD 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE	
F 456	R45 was asked if stemperature, lightin building that affects the air conditioner was noisy and cold talked to the facility reset her thermomalways work.  R45's quarterly Mir 9/1/15, indicated R had minimal hearin On 9/17/15, at 9:30 tour with the direct noise was observe cooling system whis sat in her recliner. loud, too noisy." The stated "it is fixable, if the facility performed in the facility performindicated random and documentation every staff had the TELS system (and system) and staff seven choose prioritic During kitchen tour following mechnical confirmed by the displayments.	27 p.m. during interview when the any problems with the any noise or anything else in the ed your comfort, R45 stated over her recliner in her room I. R45 further stated she had and thought they had tried to eter in the room but it did not nimum Data Set (MDS) dated 45's cognition was intact and	F 45	conduct observational/auditory resident areas daily x 2 weeks weekly x4 weeks, and finally n The Quality Assurance Performance Improvement (QAPI) will deter discontinuation of audits is indicurrent practice has been deer sustained and compliant.  The ice machines on both the Park Unit are scheduled to be 10/16/2015. To monitor comp Housekeeping will conduct au weeks, then weekly x4 weeks monthly on all ice machines in areas. The Quality Assurance Performance Improvement (Quetermine if discontinuation of indicated once current practice deemed to be sustained and continuation of indicated with a washable clip, and training was provided to a staff. Audits will be completed weeks, weekly x4, then month compliance. The Quality Assurance Improvement (Quetermine if discontinuation of indicated once current practice deemed sustained and compliance. The Quality Assurance Improvement (Quetermine if discontinuation of indicated once current practice deemed sustained and compliance. The Quality Assurance Improvement (Quetermine if discontinuation of indicated once current practice deemed sustained and compliance. The Quality Assurance Improvement (Quetermine if discontinuation of indicated once current practice deemed sustained and compliance. The Quality Assurance Improvement (Quetermine if discontinuation of indicated once current practice deemed sustained and compliance. The Quality Assurance Improvement (Quetermine if discontinuation of indicated once current practice deemed sustained and compliance. The Quality Assurance Improvement (Quetermine if discontinuation of indicated once current practice deemed sustained and compliance. The Quality Assurance Improvement (Quetermine if discontinuation of indicated once current practice deemed sustained and compliance. The Quality Assurance Improvement (Quetermine if discontinuation of indicated once current practice deemed sustained and compliance. The Quality Assurance Improvement (Quetermine if discontinuation of indicated once current practice deemed to be sustained and co	then nonthly. mance mine if icated once med to be  TCU and repaired liance, dits daily x 2 and finally resident  API) will audits is a has been compliant.  en have a duct tape be and Education II kitchen II daily x 2 ly to ensure trance API) will audits is a has been ant.		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NG		(X3) DATE SURVEY COMPLETED		
		245328	B. WING _		09	/17/2015	
	PROVIDER OR SUPPLIER	RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP C 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 456	across from the kit water dripping out have stagnant water stated that mainter responsible for the - ice machine on P across from nursin out of the ice shoot water in the catch I During a follow-up 10:15 a.m. the follo observed and verifing the inside front was closed the subholding bin of ice up brown substance on the inside front was closed the subholding bin of ice up brown substance on the inside front was closed the subholding bin of ice up brown substance on the inside front was closed the subholding bin of ice up brown substance of the inside front was closed the subholding bin of ice up brown substance of the inside front was closed the subholding bin of ice up brown substance of the inside front water of a hook lower 24 inches of piece of material water tape. This low dietary workers to each meal use.  During environment a.m. with the direct following was observed and the inside t	chenette was noted to have of the ice shoot and noted to er in the catch basin. DNS nance and housekeeping were se ice machines.  arkside unit in the hallway g station was dripping water t and noted to have stagnant basin which was not draining.  kitchen tour on 9/16/15, at owing sanitation concerns were ied by the DNS:  e kitchen had a buildup of a on the right side of the door and of the machine. When the door ostance was directly above the sed for resident use. This was easily removed and verified to the right of the unit. The the hose was taped to a hard with frayed, heavily soiled red her section was the area that inched to drain the hose after out at tour on 9/17/15, at 9:50 tor of maintenance (DM) the	F 4:	56			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245328	B. WING			09/	17/2015	
	PROVIDER OR SUPPLIER			28210 OL	DDRESS, CITY, STATE, ZIP CODE  D TOWNE ROAD  O CITY, MN 55013	, ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 456	shoot collecting the to be approximate machine was plug system to clean it.  Ice machine on the draining however with the ice shoot.  During an interview DNS stated the kit the cleaning sched last month. However, staff wiped the reconstruction to the cleaning sched last month assignment sheets maintenance were reconstructed of the unday and the concern, such as possible walls, chipping paid Review of the facil Maintenance Orded directed staff to such campus wide work issues related to perecautions and to the TELS request.	wash basin was under the ice of dripping water and was noted by 1/4 full. DM stated the ged up daily and they have a put weekly.  The Parkside unit was now water still was dripping down water still was not on dule but maintenance oleaned it was no werify this.  The cleaning schedules for May 2, 2015 indicated the kitchen ice was not on the cleaning schedules from provided.  The cleaning schedules for May 2, 2015 indicated the kitchen ice was not on the cleaning schedules from provided.  The cleaning schedules for May 2, 2015 indicated the kitchen ice was not on the cleaning schedules from provided.  The cleaning schedules for May 2, 2015 indicated the kitchen ice was not on the cleaning schedules from provided.  The cleaning schedules for May 2, 2015 indicated the kitchen ice was not on the cleaning schedules from provided.  The cleaning schedules for May 2, 2015 indicated the kitchen ice was not on the cleaning schedules for May 2, 2015 indicated the kitchen ice was not on the cleaning schedules for May 2, 2015 indicated the kitchen ice was not on the cleaning schedules for May 2, 2015 indicated the kitchen ice was not on the cleaning schedules for May 2, 2015 indicated the kitchen ice was not on the cleaning schedules for May 2, 2015 indicated the kitchen ice was not on the cleaning schedules for May 2, 2015 indicated the kitchen ice was not on the cleaning schedules for May 2, 2015 indicated the kitchen ice was not on the cleaning schedules for May 2, 2015 indicated the kitchen ice was not on the cleaning schedules for May 2, 2015 indicated the kitchen ice was not on the cleaning schedules for May 2, 2015 indicated the kitche	F 4	56				

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		245328	B. WING			09/1	17/2015
	PROVIDER OR SUPPLIER	RESIDENCE		28	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD HISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 456 F 465 SS=E	483.70(h) SAFE/FUNCTIONA E ENVIRON The facility must pr	e not in working order.  AL/SANITARY/COMFORTABL  ovide a safe, functional, ortable environment for	F 4				10/15/15
	by: Based on observareview, the facility fenvironment was must be for environment was must be for environment was must be following was noted.  R66 and R198's rounded tape approximus secure a seam on the center of the room. On the same bedroom, approximulength of the vinyl fingishing creating a areas created an unthey would need to and rewax the floor to be repaired.	naintained in a safe manner for 66, R198, R104, R106, R8) nmental concerns.  a.m. during the environmental or of maintenance (DM), the			The flooring in R66, R8 and R198's has been replaced. All staff has been ducated to report any maintenance concern using the TELs system. Education is provided at each nursing station and throughout the building of how to submit a TELs request. To monitor compliance, housekeeping conduct audits to ensure flooring is and safe for resident use daily x 2 withen weekly x4 weeks, and finally mand The Quality Assurance Performance Improvement (QAPI) will determine discontinuation of audits is indicated current practice has been deemed to sustained and compliant.  Person(s) Responsible: Director of Housekeeping or Designee  The wall tiles that were missing in the kitchen were replaced. All staff has educated to report any maintenance concern using the TELs system. Education is provided throughout the building on how to submit a TELs re	en e ng on will intact veeks, ionthly. e if d once o be	

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	PROVIDER OR SUPPLIER	RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 465	cognition and requimost activities of data R198's admission MR198 had severely required extensive R104 and R106's reapproximately five is seam on the vinyl flof the room. DM stabecause they may R104's annual MDS R104 had severely extensive assistance area assessmand R106's quarterly MR106 had severely required extensive of daily living (ADL'. R8's room had gray feet in length used flooring located at the R8's quarterly MDS had severely impair extensive assistance. During a follow-up MR10:15 a.m. the folloobserved and verification observed and verification.	R66 had severely impaired red extensive assistance with aily living (ADL's).  MDS dated 8/11/15, indicated impaired cognition and assistance with most ADL's.  Doom had gray duct tape, reet in length used to secure a coring located at the entrance ated "staff put tape on it have thought it was unsafe."  So dated 5/16/15, indicated impaired cognition, required be with most ADL's and had a cent trigger for falls.  DS dated 7/4/15, indicated impaired cognition and assistance with most activities is).  A duct tape, approximately five to secure a seam in the vinyle he entrance of the room.  A dated 6/15/15, indicated R8 red cognition and required the with most ADL's.  Kitchen tour on 9/16/15, at wing sanitation concerns were	F 465	To monitor compliance, houseke conduct audits to ensure ceiling are needing replacement are reported. TELs daily x 2 weeks, then week weeks, and finally monthly. The Assurance Performance Improvi (QAPI) will determine if disconting audits is indicated once current phas been deemed to be sustained compliant.  Person(s) Responsible: Director Housekeeping or Designee	tiles that corted in kly x4 Quality ement nuation of practice ed and		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245328	B. WING _		09/	/17/2015	
	PROVIDER OR SUPPLIER	RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION OF THE APPROVIDE ACTION OF THE APPROVIDE ACTION OF THE APPROVIDE ACT	ULD BE	(X5) COMPLETION DATE	
F 465 F 514 SS=F	stated maintenance hourly for any issue system to use and employee training."  Review of the unda LifePointes Orienta nursing assistant) chow to fill out a mai provided some exa concern, such as pwalls, chipping pain.  Review of the facility Maintenance Order directed staff to subcampus wide work issues related to paprecautions and to the TELS request. To call the on-call must be computers were 483.75(I)(1) RES RECORDS-COMPLE  The facility must mare resident in accorda standards and practacurately docume systematically orga.  The clinical record information to ident resident's assessm services provided; to	on 9/17/15, at 10:46 a.m. DM e looked at the TELS system es. DM stated "it is a very easy they go over it in new ted Ecumen Parmly tion Guide NA/R (registered lirected maintenance to teach ntenance request and mples that might be a safety lumbing problems, damaged it or wall scrapes.  By Process for Requesting spolicy dated 10/31/14, omit a TELS (an online order system) request for any attent safety such as fall identify the issue as Critical on The policy further directed staff aintenance staff member if e not in working order.  LETE/ACCURATE/ACCESSIB aintain clinical records on each nce with accepted professional tices that are complete; nted; readily accessible; and nized.  must contain sufficient ify the resident; a record of the ents; the plan of care and	F 4			10/15/15	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245328	B. WING		09/17/2015	
	PROVIDER OR SUPPLIER	RESIDENCE	:	STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013	00/11	720.0
(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 (	(X5) COMPLETION DATE
F 514	Continued From parand progress notes  This REQUIREME by: Based on interview failed to maintain a complete for 5 of 5 R127, R197) and 2 (R99, R70) reviewer reviews.  Findings include:  Current Residents: R32's diagnoses in Insomnia, hyperter congestive heart far polymyalgia rheum obtained from Adm.  R32 was admitted consultant pharma. Review recorded by	age 35 s.  NT is not met as evidenced of and record review, the facility accurate medical records were residents (R32, R81, R41, et of 2 discharged residents ed for monthly pharmacist	F 514	In relation to Resident Records Complete/Accurate/Accessible, it is policy of the facility to maintain clinic records on each resident in accorda with accepted professional standard practices; accurately documented; r accessible; and systematically orgal  In relation to residents R32, R81, R4 R127, R197, R99 and R 70, the indi medication regimen reviews have be obtained by the pharmacy and place each resident; s medical record. Ea resident; s medication regimen was reviewed by the consulting pharmacy required. The medication irregulariti been addressed by the MD/NP and placed in the resident; s chart. The consulting pharmacist would then se cumulative summary report for the	the cal ance de and readily nized.  41, ividual een ed into ch cist as es had end a	
	Lifepointes Summa the director of nurs 5/1/15, 6/2/15, 7/2/ indicated each mor all facility residents recommendations. months reviewed the irregularities and/or	sultant Pharmacist's Parmly ary Reports kept in a binder in ing office dated 3/4/15, 4/2/15, 15, 8/4/15, and 9/1/15, nthly review was inclusive for along with any pertinent. In addition of the seven here were six noted recommendations for R32.		residents reviewed at that time. If the were no irregularities, they were not the Patient Summary Report. This is has changed as each resident has a ¿Patient Summary Report; vs. an inclusive list for all the residents revelop the Pharmacist.  To improve the Medication Regiment Review process and ensure each resident summary Report, the pharmacist will provide the state of the sta	eed on system a iewed iewed esident ary the	
		cluded paralysis agitans, emplications type II,		facility with an individualized Patient Summary Report with the pertinent		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245328	B. WING		09/-	17/2015	
	PROVIDER OR SUPPLIER RGARET S PARMLY I	RESIDENCE	:	STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013	•		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 514	Ill and depressive of Physician Order Research Physician Physician Review of a Consultifepointes Summathe nursing office of review was inclusive with any pertinent ron the 8/4/15, review recommendation had 1's diagnoses in congestive heart fathypertension obtain Record printed 9/1'.  R41 was admitted consultant pharmathe Review recorded be month from October in R41's chart.  Review of the Consultifepointes Summathe nursing office of indicated each morall facility residents recommendations. 11/4/14, 1/5/15, 2/3 irregularities and/or	disorder obtained from the eport dated 9/14/15.  7/30/15. There was no cist's Medication Regimen y the pharmacist for August rt.  Itant Pharmacist's Parmly ary Reports kept in a binder in lated 8/4/15, indicated the re for all facility residents along recommendations. In addition and been identified for R81. Included alzheimer's disease, illure, diabetes and from the Admission red from the Admission red from the Admission Regimen y the pharmacist for each er 2014 thru September 2015  sultant Pharmacist's Parmly ary Reports kept in a binder in lated 10/2/14 thru 9/1/15, and 10/2/14 thru 9/1/15, and 10/2/15 and 9/1/15, noted recommendations for R41.	F 514	regulatory information. This reports scanned into the resident is merecord. This process will ensure organized, and easily accessible medication reviews.  To ensure compliance with their process, audits will be conducted ensure all current residents have Consultant Pharmacist is Medical Review Summary Report in the medical record. Chart audits with conducted for all residents reviet the Pharmacist for the next two Then, chart audits will be conducted quarterly.  The Quality Assurance Performation of audits is indicated current practice has been deem sustained and compliant.  Person(s) Responsible: Director Nursing and Consulting Pharmatical Designee	dical e timely, e monthly  new d to e a eation electronic ll be wed by months. cted  ance nine if ated once ed to be		
	R127's diagnoses i epilepsy, anxiety, ir	included Alzheimer disease, nsomnia, delusional disorder, onality disorder obtained from					

	ETATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245328	B. WING		_ 09	/17/2015	
	PROVIDER OR SUPPLIER	RESIDENCE		STREET ADDRESS, CITY, STA 28210 OLD TOWNE ROAD CHISAGO CITY, MN 550	TE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 514	R127 was admitted consultant pharmac Review available in October 2014, Dec February 2015, Ma 2015 and June 201 Review of the Consultiepointes Summathe director of nursi 5/1/15, 6/2/15, 7/2/indicated each morall facility residents recommendations. months reviewed thirregularities and/or There were no consultant pharmacist in R127 R197's diagnoses in dementia with behapolymyalgia rheums obtained from Adm R197 was admitted consultant pharmac Review available in October 2014, Dec February 2015, Ma 2015 and June 201 Review of the Consultant pharmac the director of nursishowed four irregularitient month cannot be placed ir records because the	I 12/6/13. There was no cist's Medication Regimen the medical record for ember 2014, January 2015, rch 2015, April 2015, May 5, July 2015, August 2015. Sultant Pharmacist's Parmly ary Reports kept in a binder in ing office dated 3/4/15, 4/2/15, 15, 8/4/15, and 9/1/15, anthly review was inclusive for along with any pertinent In addition of the seven here were four noted recommendations for R127. Sultant pharmacist's en Review recorded by the	F 5	514			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED		
		245328	B. WING			09/	17/2015
	PROVIDER OR SUPPLIER			2821	EET ADDRESS, CITY, STATE, ZIP CODE 10 OLD TOWNE ROAD SAGO CITY, MN 55013		,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 514	Reviews form was File (white 3 ring be at the facility. DISCHARGED RER99's diagnoses in chronic airway obsimalignant neoplas obtained from Adni R99 was admitted remained in the far Parmly Lifepointes the last consultant medical record was consultant pharma Review recorded be in R99's chart.  R70's diagnoses in disorder, insomnia and cerebrovascul physician order recorded to the last consultant medical record was consultant pharma Review recorded be last consultant medical record was consultant pharma Review recorded be 2015, or June 201  On 9/17/15, at 3:4 called no answer.  On 9/17/15, at 11:6	in the Consultant Pharmacist sinder), but was not being used ESIDENTS included chronic pancreatitis, struction, osteoporosis and im upper lobe bronchus inission Record dated 9/17/15.  Ito the facility 5/23/15, and cility until 7/5/15. Review of Summary Reports, indicated pharmacist review in the is dated 6/2/15. There was no acist's Medication Regimen by the pharmacist for June 2015.  Ito the facility 4/24/15 and cility until 6/8/15. Review of Summary Reports, indicated in the pharmacist for June 2015.  Ito the facility 4/24/15 and cility until 6/8/15. Review of Summary Reports, indicated pharmacist review in the is dated 6/2/15. There was no acist's Medication Regimen by the pharmacist for either May the pharmacist for either May	F 5	14			

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTI			E SURVEY MPLETED
		245328	B. WING			09	/17/2015
	PROVIDER OR SUPPLIER	RESIDENCE		STREET ADDRES  28210 OLD TOW  CHISAGO CIT			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	VIDER'S PLAN OF CORREC' CORRECTIVE ACTION SHOI REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 514	charts, but have not pharmacist took over the consultant Pha 1:30 p.m. the CP resummary is collate electronically and edirector of nursing, been vetted by his the monthly medical individual residents summary.  The monthly medical individual residents summary.  The monthly medical individual residents was provided a conconsultant pharmacinformation of multivity reviews, the consultant pharmacinformation of multivity reviews. To monthly medication monthly reviews. To monthly medication months would involve month to find the residual individual residents was provided a conconsultant pharmacinformation of multivity reviews. To monthly medication months would involve month to find the residuation of the Medication Residuation Residuation Residuation the residuating the residuating the residuating the residuating the residuating the residuating the determination of the medication residuating the residuation and the residuation res	charts, and used to be in the of been since the new er.  I. p.m. a voicemail was left for remacist (CP). On 9/18/15, at eturned the call and stated the donto a computer form, emailed or handed to the and that this process had director. The CP verified that ation review was not in each a chart, since it was a collated eation review information was attained on a pharmacy based of available within each a medical record. The DON by of each visit by the cist. The form contained the inple patients monthly chart attant pharmacist visited the thorough the prior 12 by looking at two printouts per esidents medication changes do then the summary of additional pages which	F 5	14			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245328	B. WING			09/	17/2015
	PROVIDER OR SUPPLIER	RESIDENCE	STREET ADDRESS, CITY, STATE, ZIP CODE  28210 OLD TOWNE ROAD  CHISAGO CITY, MN 55013				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	related to medication recommendations a nursing and the atte appropriate the medicadministrator  The facility lacked to medication reviews	ge 40 res adverse consequences on therapy. Findings and are reported to the director of ending physician, and if dication director and/or  the necessary monthly available in the individual in the closed medical records.	F 5	114			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/20/2015 FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 245328 09/21/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 28210 OLD TOWNE ROAD THE MARGARET S PARMLY RESIDENCE CHISAGO CITY, MN 55013 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)ID (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **TAG** DEFICIENCY) K 000 K 000 **INITIAL COMMENTS** FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State

Fire Marshal Division. At the time of this survey The Margaret Parmley Residence building 01 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.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K TAGS) TO:** 

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

HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION

TITLE

(X6) DATE

**Electronically Signed** 

10/15/2015

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245328	B. WING	i		09/	21/2015
	PROVIDER OR SUPPLIER	RESIDENCE		:	STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	ST. PAUL, MN 5510 By e-mail to: Marian.Whitney@s or Angela.Kappenmar  THE PLAN OF COI DEFICIENCY MUS FOLLOWING INFO  1. A description of v to correct the deficit 2. The actual, or pro 3. The name and/or responsible for corr prevent a reoccurre  The Margaret Parm building with a no be constructed in 1972 with an addition, in	STREET, SUITE 145 01-5145, or  tate.mn.us  n@state.mn.us  RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency.  pposed, completion date.	K	000			
	connected and prop	perly fire separated. Therefore, ected as two different					
	facility has a comple smoke detection in that is monitored for notification. The fac	fire sprinkler protected. The ete fire alarm system with spaces open to the corridor, r automatic fire department elity has a licensed capacity of a census of 93 at the time of					

PRINTED: 10/20/2015 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPF DEPLAY OF CORRECTION (X1) PROVIDER/SUPF IDENTIFICATION				E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245328	B. WING			09/21/2015	
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD HISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
K 000	Continued From p	age 2	K	000			
K 011 SS=F	NOT MET. NFPA 101 LIFE SA  If the building has nonconforming bu barrier having at le rating constructed addition. Communicorridors and are p	at 42 CFR Subpart 483.70(a) is AFETY CODE STANDARD a common wall with a ilding, the common wall is a fire east a two-hour fire resistance of materials as required for the nicating openings occur only in protected by approved ors. 19.1.1.4.1, 19.1.1.4.2	K	011			10/15/15
	Based on observarevealed that 2 of found not in compl Safety Code" 2000 19.1.1.4.1 and 19. conditions could atto travel from one negatively affect the facility.  Findings include:  On facility tour bet 09/21/2015, observed.	is not met as evidenced by: ations and staff interview, it was 3 fire separations that were iance with NFPA 101 "The Life 0 edition (LSC) section 1.1.4.2,. These deficient low the products of combustion building to another, which could be residents, staff and visitors  ween 10:30 AM to 2:30 PM on vations revealed that the conditions were found affecting fire separations:			The penetration above the fire doors separates the chapel from the care of has been sealed with 3M Fire Barrier Sealant. A checklist has been created that any future construction and/or electrical projects will be inspected by Engineering Director to ensure fire with barriers are intact.  Fire doors located between the chape and care center were repaired on 10/13/2015. A full audit of 100% the center fire doors was completed to eall fire doors close properly. Fire door will be inspected during each fire drill ensure proper function.	center r · ed so y the vall el care nsure ors	
		etration found above the doors all that separates the chapel er,			The 2x4 opening in the ceiling tile neulsabelle¿s House has been repaired, checklist has been created so that ar future construction and/or electrical	. A	

Facility ID: 00065

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO.				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		) MULTIPLE CONSTRUCTION BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245328	B. WING			09/	21/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE MAI	RGARET S PARMLY F	RESIDENCE			8210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 011	separating the char not fully close and l 3. there is a 2 by 4 located in the 2 hou	ge 3 If in the 2 hour fire wall that is pel from the care center did atch into the rated frame, and copening above the ceiling tile in fire wall separating the care center from the assisted	ΚŒ	<b>D11</b>	projects will be inspected by the Engineering Director to ensure fire barriers are intact.  Director of Maintenance and/or de will be responsible for ongoing compliance.		
K 017 SS=D	Maintenance Direct NFPA 101 LIFE SAI Corridors are separ constructed with at rating. In sprinklere required to resist th non-sprinklered build above the ceiling. (at the underside of permitted by Code. waiting areas, dining may be open to the conditions specified be separated from constructions.)	rated from use areas by walls least ½ hour fire resistance ed buildings, partitions are only e passage of smoke. In ldings, walls properly extend Corridor walls may terminate ceilings where specifically Charting and clerical stations, g rooms, and activity spaces corridor under certain in the Code. Gift shops may corridors by non-fire rated is fully sprinklered.)	KC	)17			10/15/15
The state of the s	Based on observat	s not met as evidenced by: ions and staff interview, it was cility had penetrations located			The hole identified in the wall pass through the oxygen room into the a		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY PLETED
		245328	B. WING_		09/	21/2015
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP C 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
K 017	not in compliance of 101 (00) Sections resisting the passa conditions could in smoke and flames effected corridors a untenable, which conting residents, so Findings include:  On facility tour betwoeld of the condition of the co	s located in the facility that are with NFPA Life Safety Code 19.3.6.2 and 8.2.4.4.1 in ge of smoke. This deficient the event of a fire, allow to spread throughout the and areas making them ould negatively affect the taff and visitors.  Ween 10:30 AM to 2:30 PM on vations revealed, that there is nole passing through the wall of supply storage room into the supply storage room into the or (MC).  FETY CODE STANDARD or soft of 13/4 inch solid-bonded core of resisting fire for at least 20 sprinklered buildings are only ne passage of smoke. There is the closing of the doors. Doors a means suitable for keeping outch doors meeting 19.3.6.3.6 prohibited by CMS regulations	K 0	storage room into the corric repaired. All staff has been report any maintenance cor TELs system. Education is each nursing station and the building on how to submit a Director of Maintenance and will be responsible for ongo compliance.	e educated to neern using the provided at roughout the TELs request. d/or designee	. 10/15/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED			
		245328	B. WING _		09/21/2015			
	PROVIDER OR SUPPLIER RGARET S PARMLY F	RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION			
K 018	Continued From pa	ge 5	K 01	8				
	Based on observath had 1 of several conthe requirements of 19.3.6.3.2. This definition is afety of all resident from a fire were allocorridors making it.  Findings include:  On facility tour betwelling to 19/21/2015, observation of 19/21	veen 10:30 AM to 2:30 PM on ations revealed that the conditions were found affecting barrier separations:		The door latch to room 119 has been repaired and is working properly. The facility will monitor and sustain corresponding audits on 10% of residuors monthly. The results of audits be reviewed in QAA and determination be made for continued audits.  The Dutch Style Doors have been secured together as one and an auticloser has been installed on the docensure both door leaves close toget the event of an emergency.  Director of Maintenance and/or designal.	he ection dent s will ion will omatic or to ther in			
	shut and latch in the 2. there are 2 Dutch leaves that did not a	n style door that had door automatically latch together to or leaves will close together in		will be responsible for ongoing compliance.				
K 029 SS=F	Maintenance Direct NFPA 101 LIFE SA	tion was verified by the or (MC). FETY CODE STANDARD construction (with ¾ hour	K 02	19	10/15/15			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION 101 - MAIN BUILDING 01		PLETED
		245328	B. WING			09/2	21/2015
	PROVIDER OR SUPPLIER	RESIDENCE		2	STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 029	fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro- the approved auton option is used, the a other spaces by sm doors. Doors are s field-applied protect	an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from toke resisting partitions and elf-closing and non-rated or tive plates that do not exceed bottom of the door are	K	029			·
	Based on observat revealed that the fa proper protection for areas located throu accordance with NF section 19.3.2.1. Tin the event of a fire spread throughout the areas making them negatively affect the residents, staff and Findings include:  On facility tour betw 09/21/2015, observe following deficient or rooms throughout the second staff and the second staff an	FPA Life Safety Code 101 (00) his deficient conditions could be, allow smoke and flames to the effected corridors and untenable, which could be exiting capabilities for visitors.  If you will be a condition of the conditions hazardous storage will be seen 10:30 AM to 2:30 PM on ation revealed, that the conditions hazardous storage			The 6x8" penetration identified ceithe Park Unit Mechanical Room have repaired. A checklist has been creathat any future construction and/or electrical projects will be inspected Engineering Director to ensure fire barriers are intact.  A door closer has been added to the Unit Mechanical Room. The Maintenance Director has identified door with a closer on it. The facility monitor and sustain correction by completing an audit of 10% of all dwith closers on them monthly. The of audits will be reviewed in QAA a determination will be made for conaudits.  Proper closers have been installed both the Chapel Storage Room Doo Maintenance Director has identified	by the wall  ne Park d each y will oors e results nd tinued on oor and r. The	
	2. the door to the F	Park Unit mechanical room			Maintenance Director has identifie door with a closer on it. The facilit		CONTRACTOR OF THE PROPERTY OF

PRINTED: 10/20/2015 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
NAME OF	PROVIDER OR SUPPLIER	245328	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	09/	21/2015
THE MA	THE MARGARET S PARMLY RESIDENCE				8210 OLD TOWNE ROAD HISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
	4. the Chapel med positively close and This deficient cond Maintenance Direct NFPA 101 LIFE SA	with a door closer, age room door did not d latch into the frame, and chanical room door did not d latch into the frame.  lition was verified by the		029	monitor and sustain correction by completing an audit of 10% of all of with closers on them monthly. The of audits will be reviewed in QAA adetermination will be made for conaudits.  Director of Maintenance and/or de will be responsible for ongoing compliance.	e results and ntinued	10/15/15
	Based on observa staff, the facility ha emergency lighting accordance with N and 19.2.9.1. This residents, staff and emergency evacual Findings include:  On facility tour betw 09/21/2015, during emergency battery maintenance documents of the Maintenance During the facility failed to	is not met as evidenced by: tions and an interview with s failed to ensure that has been tested in FPA LSC (00) Section 7.9.3, deficient practice could I visitors in the event of an ation during a power outage.  I visitors in the event of an ation during a power outage.  I visitors in the event of an ation during a power outage.  I visitors in the event of an ation during a power outage.  I visitors in the event of an ation during a power outage.  I visitors in the event of an ation during a power outage.	The property of the property o		All EXIT lights were tested to ens proper function. Education was proper function. Education was proper functioning of lights and regulatory guidelines. The facility monitor and sustain correction by all monthly 30 second and annual minute testing in the electronic preventative maintenance program (TELs), where they will be tracked stored.  Director of Maintenance and/or de will be responsible for ongoing compliance.	rovided o check d will placing 90 m	

PRINTED: 10/20/2015 FORM APPROVED OMB NO. 0938-0391

T OF DEFICIENCIES	I			1	
EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBE			PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
	245328	B. WING		09/	21/2015
	DECIDENCE	t t			
RGARETS PARMLY	RESIDENCE		CHISAGO CITY, MN 55013		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHO	JLD BE	(X5) COMPLETION DATE
Continued From pa	age 8	K 046	3		
Maintenance Direc NFPA 101 LIFE SA	tor (MC). FETY CODE STANDARD	K 050			10/15/15
varying conditions, The staff is familiar that drills are part of Responsibility for p assigned only to co qualified to exercis conducted between announcement ma	at least quarterly on each shift. with procedures and is aware of established routine. clanning and conducting drills is competent persons who are the leadership. Where drills are to 9 PM and 6 AM a coded by be used instead of audible				
Based on review of interview, it was de to conduct fire drills Safety Code 101(0 12-month period. Taffect how staff rea	of reports, records and staff termined that the facility failed in accordance with NFPA Life 0), 19.7.1.2, during the last this deficient practice could not in the event of a fire.		thorough search of records and access to old TELs reports. Col Fire Drill records were found for quarters in question. The facility monitor and sustain compliance placing all planned quarterly fire the electronic preventative main	gained mpleted all of the / will by drills in tenance	
On facility tour betw 09/21/2015, during maintenance docur the Maintenance D that the facility faile	the review of all available mentation and interview with irector (MC) it was revealed d to provide the following fire		Director of Maintenance and/or will be responsible for ongoing compliance.	designee	
	PROVIDER OR SUPPLIER  RGARET S PARMLY I  SUMMARY STA (EACH DEFICIENC REGULATORY OR I  Continued From pa  This deficient cond Maintenance Direct NFPA 101 LIFE SA  Fire drills are held varying conditions, The staff is familian that drills are part of the staff is familian that drills are part of the staff is familian that drills are part of qualified to exercis conducted between announcement material alarms. 19.7.1.2  This STANDARD is Based on review of interview, it was detended to conduct fire drills safety Code 101(0) 12-month period. The staff real interview is the staff real interview in the staff real interview.  Findings include:  On facility tour betwol/21/2015, during maintenance document of the Maintenance Dethat the facility failer.	PROVIDER OR SUPPLIER  RGARET'S PARMLY RESIDENCE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8  This deficient condition was verified by the Maintenance Director (MC). NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents.	PROVIDER OR SUPPLIER  RGARET S PARMLY RESIDENCE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8  This deficient condition was verified by the Maintenance Director (MC).  NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine.  Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all residents.  Findings include:  On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, during the review of all available maintenance documentation and interview with the Maintenance Director (MC) it was revealed that the facility failed to provide the following fire	PROVIDER OR SUPPLIER  RGARET S PARMLY RESIDENCE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8  This deficient condition was verified by the Maintenance Director (MC).  NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine.  Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. 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Findings include:  On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, during the review of all available maintenance documentation and interview with the Maintenance Director (MC) it was revealed that the facility failed to provide the following fire	PROVIDER OR SUPPLIER  RGARET S PARMLY RESIDENCE  SIMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FUIL) REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 8  This deficient condition was verified by the Maintenance Director (MC). NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct fire drills in accordance with NFPA Life Safety Code 101(00), 19.7.1.2, during the last 12-month period. This deficient practice could affect how staff reach in the event of a fire. Improper reaction by staff would affect the safety of all residents.  On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, during the review of all available maintenance documentation and interview with the Maintenance Director (MC); it was revealed that the facility failed to provide the following fire

Facility ID: 00065

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO.				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>f</b> ` '	IPLE CONSTRUCTION NG <b>01 - Main Building 01</b>		E SURVEY IPLETED	
		245328	B. WING		09/	21/2015	
	PROVIDER OR SUPPLIER  RGARET S PARMLY F	RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
K 050	•	-	К0	50			
	2. a overnight sniπ quarter,	drill in the first calendar					
	3. a day shift drill in	the second calendar quarter,					
	4. a evening shift di quarter,	ill in the third calendar				and the section and the section of t	
	5. a overnight shift quarter,	drill in the third calendar				Transmission of the Production of the	
	6. a overnight shift quarter,	drill in the fourth calendar	The state of the s			A CANALIS AND A	
K 052	Maintenance Direct	tion was verified by the or (MC). FETY CODE STANDARD	K 0	52		10/15/15	
SS=F	installed, tested, an with NFPA 70 Natio 72. The system has	required for life safety is d maintained in accordance nal Electrical Code and NFPA an approved maintenance a complying with applicable PA 70 and 72. 9.6.1.4					
			TO THE			Accordance and the second seco	
	Based on observat	s not met as evidenced by: ion and staff interview, it was cility had failed to install and		Maintenance Director complete thorough search of records and			

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				VID IVO.	0930-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245328	B. WING	G09i			21/2015
	PROVIDER OR SUPPLIER RGARET S PARMLY I	RESIDENCE		2	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD HISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 052	the requirements of 19.3.4.1 and 9.6, and Sections 7.1. This adversely affect the system, and could and emergency actions.	arm system in accordance with f 2000 NFPA 101, Sections s well as 1999 NFPA 72, deficient condition could e functioning of the fire alarm delay the timely notification tions for the facility thus all residents, staff, and	ΚO	52	to locate the annual testing documentation of the fire alarm systhat was completed on February 10. The facility will monitor and sustain compliance by placing all planned fire alarm testing in the electronic preventative maintenance program (TELs), where it will be tracked and stored.	), 2015. I annual I	
	09/21/2015, observed review of all availate for the last 12 monomial Maintenance Direct at the time of the innot provide any curtheir fire alarm systems.	ition was verified by the			Director of Maintenance and/or deswill be responsible for ongoing compliance.	signee	
K 054 SS=F	NFPA 101 LIFE SA All required smoke activating door hold maintained, inspec	detectors, including those dependences, are approved, ted and tested in accordance rer's specifications. 9.6.1.3	K0	54			10/15/15
	Based on staff inte	s not met as evidenced by: erview and a review of the tation, the facility has not uired sensitivity testing of the			Maintenance Director completed a thorough search of records and wat to locate the sensitivity testing of e	is able	

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				IVID IVO.	0830-0381
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245328	B. WING			09/	21/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
THE MAI	RGARET S PARMLY I	RESIDENCE			8210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		*
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 054	smoke detectors of accordance with NI Code (99), Sec. 7-3 could affect all residual	n the fire alarm system in FPA 72 National Fire Alarm 3.2.1. This deficient practice dents, visitors, and staff.  ween 10:30 AM to 2:30 PM on ew of the facility's available fire and testing documentation for and an interview with the tor (MC) revealed that at the on the facility could not provide entation verifying the equired sensitivity testing of tor located throughout the desire it is ance with NFPA 13, Standard of Sprinkler system, it is ance with NFPA 13, Standard of Sprinkler Systems, to everage for all portions of the em is properly maintained in FPA 25, Standard for the and Maintenance of Protection Systems. It is fully is a reliable, adequate water em. Required sprinkler bed with water flow and tamper electrically connected to the		054	smoke detector located throughou facility that was completed on February 2014. The facility will monitor and compliance by placing all required testing of the sensitivity of the smodetectors in the electronic prevents maintenance program (TELs), whe will be tracked and stored.  Director of Maintenance and/or de will be responsible for ongoing compliance.	ruary 5, sustain annual ke ative ere they	10/15/15

Facility ID: 00065

CENTER	49 FOR MEDICARE	& MEDICAID SERVICES					0000-0001
	IENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATI COM	
		245328	B. WING			09/2	21/2015
	PROVIDER OR SUPPLIER	RESIDENCE		28	REET ADDRESS, CITY, STATE, ZIP CODE 3210 OLD TOWNE ROAD HISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE.	(X5) COMPLETION DATE
K 056	Continued From pa	age 12	KO	56			
	Based on observa found that the auto installed and maint NFPA 13 the Stand Sprinkler Systems the sprinkler syster (99) could allow sys- causing a decrease capability in the ever-	s not met as evidenced by: tions and staff interview, it was matic sprinkler system is not ained in accordance with lard for the Installation of (99). The failure to maintain in compliance with NFPA 13 stem being place out of service in the fire protection system ent of an emergency that sidents, visitors and staff of the			Missing escutcheon rings were repon 10/15/2015. The facility will mo and sustain correction by completing audit of 10% of all sprinkler heads monthly. The results of audits will reviewed in QAA and determination made for continued audits.  Director of Maintenance and/or deswill be responsible for ongoing compliance.	nitor ng an be n wìll be	
	Findings include:						
	09/21/2015, observ	veen 10:30 AM to 2:30 PM on vations revealed that there are con ring located near resident					
K 062 SS=F	Maintenance Direc NFPA 101 LIFE SA Required automatic continuously mainte condition and are in	ition was verified by the tor (MC). FETY CODE STANDARD c sprinkler systems are ained in reliable operating aspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25,	KC	162			10/15/15
	Based on docume	s not met as evidenced by: ntation review and interview y has failed to properly inspect	THE RESERVE TO THE RE		Maintenance Director completed a thorough search of records and wa		

	KO FUK MEDIUAKE	: & MEDICAID SERVICES				IVID IVO.	0930-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245328	B. WING			09/2	21/2015
	PROVIDER OR SUPPLIER RGARET S PARMLY I	RESIDENCE		28	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD HISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPRIES OF THE APPROPROPRIES OF THE APPROPRIES	BE	(X5) COMPLETION DATE
K 062	and maintain the araccordance with Ni Section 19.7.6, and of Sprinkler System for the Inspection, Water Based Fire I deficient practice d sprinkler system is fully operational in negatively affect re  Findings include:  On facility tour betw 09/21/2015, a revie interview with the I revealed that at the facility failed to procurrent annual fire completed.  This deficient cond Maintenance Direct NFPA 101 LIFE SA Portable fire exting health care occupa	utomatic sprinkler system in FPA 101 Life Safety Code (00), 4 4.6.12, NFPA 13 Installation as (99), and NFPA 25 Standard Testing and Maintenance of Protection Systems, (98). This oes not ensure that the fire functioning properly and is the event of a fire and could sidents, staff and visitors.  In the event of a fire and could sidents, staff and visitors.  In the event of a fire and could sidents, staff and visitors.  In the event of a fire and could sidents, staff and visitors.  In the event of a fire and could sidents, staff and visitors.  In the event of the inspection the evide any documentation for a sprinkler test having been sition was verified by the	K	062	to locate the annual fire sprinkler to was completed on February 10, 20. The facility will monitor and sustain compliance by placing all planned a fire sprinkler testing in the electronic preventative maintenance program (TELs), where it will be tracked and stored.  Director of Maintenance and/or deswill be responsible for ongoing compliance.	15. annual ic i	10/15/15
	Based on docume interview, it was de	s not met as evidenced by: ntation review and staff termined that the facility failed e fire extinguishers in			Monthly fire extinguisher inspectio be completed timely. The facility w monitor and sustain compliance by	/ill	

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VENTE	49 FOR MEDICARE	& MEDICAID SERVICES	·			110 110.	0000-0001
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION 11 - MAIN BUILDING 01		E SURVEY PLETED
		245328	B. WING	*********		09/2	21/2015
	PROVIDER OR SUPPLIER RGARET S PARMLY I	RESIDENCE		28	REET ADDRESS, CITY, STATE, ZIP CODE 1210 OLD TOWNE ROAD HISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 064 K 067 SS=F	9.7.4.1 and NFPA could affect all resinguishers that a facility.  This deficient cond Maintenance Direct NFPA 101 LIFE SA Heating, ventilating with the provisions in accordance with	PPA 101-2000 edition, Section 10. This deficient practice dents, staff and visitors.  In the staff and visitors are staff and visitors.  In the staff and visitors are staff and visitors are located throughout the staff are located by the staff are staff ar	К0		scheduling all fire extinguisher inspin the electronic preventative maintaprogram (TELs), where it will be trained stored. Monthly audits will be completed on 5 extinguishers per many the results of audits will be reviewed QAA and determination will be mad continued audits.  Director of Maintenance and/or deswill be responsible for ongoing compliance.	enance cked nonth. ed in le for	10/15/15
	Based on docume interview, the fire/si been maintained in requirements of NF deficient practice disperation of the fire allow smoke migration.	s not met as evidenced by: ntation review and staff moke damper system has not accordance with the PA 90(99) section 3-4.7. This bes not ensure the proper elsmoke dampers and could cion to negatively affect the tts, staff and visitors in the			Maintenance Director completed a thorough search of records and was to locate the annual damper testing document that was completed on February 10, 2015. The facility will monitor and sustain compliance by placing all scheduled damper tests electronic preventative maintenance.	s able	

Event ID: ZNE521

	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 11 - MAIN BUILDING 01		SURVEY PLETED
		245328	B. WING			09/2	21/2015
	DF PROVIDER OR SUPPLIER			28	REET ADDRESS, CITY, STATE, ZIP CODE 1210 OLD TOWNE ROAD HISAGO CITY, MN 55013		
(X4) II PREFI TAG	X (EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY-MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	Χ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 06	Continued From p event of a fire.	age 15	K0	67	program (TELs), where it will be tra	cked	
	09/21/2015, it was the facility's fire an test/inspection dod by interview with that the facility had documentation ver	cumentation and was confirmed ne Maintenance Director (MC),			Director of Maintenance and/or deswill be responsible for ongoing compliance.	signee	
K 06 SS=	Maintenance Direction NFPA 101 LIFE SA	AFETY CODE STANDARD are protected in accordance	K0	69			10/15/15
	Based on docume interview, it was do failed to ensure the inspections of the fire suppression sy appliances have been table 8-3.1, stacooking operations components shall semiannually by a certified company	is not met as evidenced by: entation review and staff etermined that the facility has at 1 of 2 semi-annual kitchen hood ventilation and ystem protecting the cooking een completed. NFPA 96 8-3.1 ates that for moderate-volume s, the hood system and be inspected and maintained properly trained, qualified, and or person. This deficient ect residents, all kitchen staff			Maintenance Director completed at thorough search of records and was to locate the semi annual Kitchen F Ventilation and Fire Suppression Stanspections Report dated 1/30/15. Another inspection was scheduled completed on 10/5/2015. The facil monitor and sustain compliance by placing all scheduled Kitchen Hood Ventilation and Fire Suppression Stanspections in the electronic prever maintenance program (TELs), whe be tracked and stored.	s able dood ystem and ity will ystem ystem htative	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245328	B. WING			09/	21/2015
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD CHISAGO CITY, MN 55013	1 00	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y-MUST BE PRECEDED BY FULL- LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 069	Continued From p	age 16	K(	)69			
	09/21/2015, during documentation for and fire suppression and interview with (MC), the facility fareports showing the and fire suppression.	ween 10:30 AM to 2:30 PM on the review of all available the kitchen hood ventilation on system inspection reports, the Maintenance Director alled to provide 2 of 2 service at the kitchen hood ventilation on system has been ected within the last 12 month	Andrew Property of Charles In which is a		Director of Maintenance and/or dewill be responsible for ongoing compliance.	signee	
K 076 SS=D	Maintenance Direct NFPA 101 LIFE SA Medical gas storage	AFETY CODE STANDARD  ge and administration areas are dance with NFPA 99, Standards	K	)76			10/15/15
		e locations of greater than closed by a one-hour	ANALIA NANALI PROGRAMA I PRIMA NANA PI JANGAR MANANANA				
	(b) Locations for si 3,000 cu.ft. are ver 4.3.1.1.2, 19.3.2.4	upply systems of greater than named to the outside. NFPA 99					
	Observations reve	is not met as evidenced by: ealed that the oxygen storage ntained in accordance with	AND INCOMPOSED INCOMPO		Fan motor for ventilation unit was replaced. The facility will monitor a	and	***************************************

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CENTERS FOR I	MEDICARE	E & MEDICAID SERVICES				1100.110.	0300-0001
STATEMENT OF DEFICIE AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245328	B. WING			09/	21/2015
NAME OF PROVIDER OF		RESIDENCE		28	TREET ADDRESS, CITY, STATE, ZIP CODE B210 OLD TOWNE ROAD HISAGO CITY, MN 55013		
PREFIX (EAC	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
(1999 ed practice atmosph growth. and visite Findings On facilit 09/21/20 gaseous located i in the ox an aggre is greate observed being sto dedicate natural voxygen scubic fee This defi Maintena NFPA 10 Generate under located in the oxing storage of the second	Standard dition) sect could create that could create that could create that could create include:  Ity tour between the extension of the oxygygen storate amount of that the rored in was defended in the oxygen create of compile to for age roce of the could could be of the could be of th	s for Health Care Facilities ion 4-3.1.1.2. This deficient atte an oxygen enriched ould contribute to rapid fire inegatively residents, staff, event of an emergency.  Ween 10:30 AM to 2:30 PM on observed that the number of oxygen cylinders that are en storage room that is located ant of compressed gases that 0 cubic feet. It was also soom that these cylinders are sonot vented to the outside by a local ventilation system or eans that is in accordance with the own that have more than 3000 ressed gases.		076	sustain correction by completing wandits to ensure proper function of ventilation fan.  Director of Maintenance and/or de will be responsible for ongoing compliance.	f the	10/15/15

Event ID: ZNE521

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CLIVIL	<u> 19 LOV MEDICH</u> LI	& MEDICAID SERVICES					0000-0001	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		SURVEY PLETED	
		245328	B. WING			09/2	21/2015	
	PROVIDER OR SUPPLIER RGARET S PARMLY I	RESIDENCE		28	TREET ADDRESS, CITY, STATE, ZIP CODE 3210 OLD TOWNE ROAD HISAGO CITY, MN 55013			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE.	(X5) COMPLETION DATE	
K 144	Continued From pa	age 18	K 1	44				
	Based on docume interview, the facility generators in acco of 2000 NFPA 101 6-4.2 (a) & (b) and could affect all resi event of an emerge Findings include:  On facility tour betw 09/21/2015, documented facility could not documentation for	veen 10:30 AM to 2:30 PM on nentation review of the tor testing logs indicated that			Weekly and monthly generator test currently being completed and logge Maintenance staff were educated or to complete the tests. The Policy ar Procedure for generator testing was reviewed and is current. The facility monitor and sustain compliance by completing monthly audits of generatest log. The results of audits will be reviewed in QAA and determination made for continued audits.  Director of Maintenance and/or designation will be responsible for ongoing compliance.	ed. n how nd s / will ator e will be		
K 147 SS=D	Maintenance Direc NFPA 101 LIFE SA Electrical wiring an	ition was verified by the tor (MC). FETY CODE STANDARD d equipment is in accordance ional Electrical Code. 9.1.2	K 1	47			10/15/15	
	Based on observa the facility was not devices in accorda National Electrical	s not met as evidenced by: tion and interview with the staff limiting storage near electrical nce with NFPA 70 (99), Code. This deficient practice fect the safety of residents, the facility.			Storage room has been cleaned an organized. Par levels for items were adjusted as to not have as many combustible items in the storage clowheelchairs were removed and org for easy access to electrical panels. Floors and walls were clearly market	e oset. ganized		

Event ID: ZNE521

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	LE CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245328	B. WING		09/	21/2015
	PROVIDER OR SUPPLIER RGARET S PARMLY F	RESIDENCE	2	STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013	·	
 (X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDEFICIENCY)	D.BE	(X5) COMPLETION DATE
K 147 K 154 SS=F	o9/21/2015, observed an excessive amoustored around and extransformers and powheel chair storage.  This deficient condification Maintenance Direct NFPA 101 LIFE SALE Where a required a out of service for material period, the authority and the building is exacted system is pro-	veen 10:30 AM to 2:30 PM on ations revealed that there was nt of combustible items being up against the electrical anels that are located in the room.  tion was verified by the or (MC). FETY CODE STANDARD  utomatic sprinkler system is ore than 4 hours in a 24-hour a having jurisdiction is notified, evacuated or an approved fire ovided for all parties left shutdown until the sprinkler	K 147	red tape for staff to visualize wher cannot store items. Staff education provided. The facility will monitor sustain compliance by completing audits of the storage rooms. The of audits will be reviewed in QAA adetermination will be made for conducts.  Director of Maintenance and/or dewill be responsible for ongoing compliance.	on was and monthly results and ntinued	10/15/15
	Based on a record facility has failed to acceptable written per followed in the esprinkler system has for four or more hoodeficient practice confor early response as	s not met as evidenced by: review and staff interview, the provide a complete and policy containing procedures to vent that the automatic fire s to be placed out-of-service ars in a 24 hour period. This build affect the facility's ability and notification of a fire and ety of all residents, visitors		Maintenance Director completed thorough search of records and w to locate the Automatic Fire Sprinl System Out of Service Policy. Th was reviewed and is accurate.  Director of Maintenance and/or de will be responsible for ongoing compliance.	as able der e policy	

		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
Constant Con			245328	B. WING			09/2	21/2015
		PROVIDER OR SUPPLIER	RESIDENCE		28	TREET ADDRESS, CITY, STATE, ZIP CODE 3210 OLD TOWNE ROAD HISAGO CITY, MN 55013		
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	K 154	Continued From pa	age 20	K '	154			
	K 155 SS=F	09/21/2015, during interview with the fat the facility coul automatic fire sprin policy.  This deficient cond Maintenance Direct NFPA 101 LIFE SA Where a required for service for more that the authority having building is evacuate provided for all part	FETY CODE STANDARD  ire alarm system is out of an 4 hours in a 24-hour period, g jurisdiction is notified, and the ed or an approved fire watch is ties left unprotected by the fire alarm system has been	K	155			10/15/15
		Based on a record facility has failed to acceptable written per followed in the ealarm system has to four or more hours deficient practice of for early response a	s not met as evidenced by: review and staff interview, the provide a complete and policy containing procedures to event that the automatic fire o be placed out-of-service for in a 24 hour period. This ould affect the facility's ability and notification of a fire and fety of all residents, visitors			Maintenance Director completed a thorough search of records and wa to locate the Automatic Fire Alarm Out of Service Policy. The policy was reviewed and is accurate.  Director of Maintenance and/or deswill be responsible for ongoing compliance.	is able System vas	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION 11 - MAIN BUILDING 01	(X3) DAT COM	E SURVEY IPLETED
		245328	B. WING	ì		09/	21/2015
	PROVIDER OR SUPPLIER RGARET S PARMLY I		.!	28	REET ADDRESS, CITY, STATE, ZIP CODE 210 OLD TOWNE ROAD HISAGO CITY, MN 55013	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 155	Continued From pa	age 21	к	155			TANANAN TONAN
	09/21/2015, during interview with the fathat the facility coulautomatic fire alarr	ween 10:30 AM to 2:30 PM on record review and an acility manager, it was found ld not provide a complete in system out of service policy. Ition was verified by the tor (MC).					
							or annual manual constitution of the constitut

T5328024

PRINTED: 10/20/2015 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 02 - THE MARGARET S. PARMLEY RESIDENCE B. WING 245328 09/21/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 28210 OLD TOWNE ROAD THE MARGARET S PARMLY RESIDENCE CHISAGO CITY, MN 55013 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 000 K 000 INITIAL COMMENTS **FIRE SAFETY** THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE **REGULATIONS HAS BEEN ATTAINED IN** ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, The Margaret S. Parmly Residence building 02 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), **EPOC** Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION (X6) DATE

Electronically Signed

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

10/15/2015

TITLE

CENT	KS FOR MEDICARI	E & MEDICAID SERVICES				JIVID IVO.	0930-0391
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	26 85	DING	LE CONSTRUCTION 6 <b>02 - THE MARGARET S. PARMLEY</b> E		E SURVEY IPLETED
		245328	B. WING	·		09/	21/2015
18	PROVIDER OR SUPPLIER	RESIDENCE		2	STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	445 MINNESOTA ST. PAUL, MN 551  By e-mail to: Marian.Whitney@sor Angela.Kappenma  THE PLAN OF CODEFICIENCY MUSTOLLOWING INFO  1. A description of to correct the defice  2. The actual, or property of the second of	STREET, SUITE 145 01-5145, or state.mn.us n@state.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done	K	000			
	buildings. The 200 with no basement a Type II(111) constructed from the original bufacility on both level. The building is fully facility has a fire also smoke detection at that is monitored for notification. All resistation smoke detections	surveyed as two separate 7 addition is a 2-story building and was determined to be of uction. The upper floor has 12 d the lower level has a pool ons. It is properly separated uilding and an assisted living els.  I sprinkler protected. The arm system, with full corridor and spaces open to the corridor, or automatic fire department ident rooms have single actors that are interconnect with ransmit to the nurses station.					

STATEMENT	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ING	02 - THE MARGARET S. PARMLEY	(X3) DATE SURV COMPLETED 09/21/20	
	PROVIDER OR SUPPLIER		D. WINC	S' 2	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD CHISAGO CITY, MN 55013	0972	21/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
K 000	The facility has a li and had a census	icensed capacity of 101 beds of 93 at the time of the survey.	K	000			
K 029 SS=D	NOT MET. NFPA 101 LIFE SA Hazardous areas a with 8.4. The area fire-rated barrier, without windows (i	at 42 CFR Subpart 483.70(a) is AFETY CODE STANDARD are protected in accordance as are enclosed with a one hour with a 3/4 hour fire-rated door, in accordance with 8.4). Doors automatic closing in .2.1.8. 18.3.2.1	K	029			10/15/15
	Based on observarevealed that the farevealed that the farevealed that the farevealed throughout accordance with N section 18.3.2.1. In the event of a fir spread throughout areas making then negatively affect the residents, staff and Findings include:  On facility tour beta	ween 10:30 AM to 2:30 <b>PM o</b> n			The 1" hole and opening around the pipes in the humidifier room have been repaired. A checklist has been created that any future construction and/or electrical projects will be inspected by Engineering Director to ensure fire was barriers are intact.  The door to the TCU Soiled Utility Room has been repaired so that it positively latches into the frame. The facility will monitor and sustain correction by completing audits on ALL Soiled Utility Room doors monthly. The results of audits will be reviewed in QAA and determination will be made for continuantity.	d so the II	
		vation revealed, that the conditions hazardous storage the facility:			audits.  The Woodworking door closer was		

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - THE MARGARET S. PARMLEY RESIDENCE			E SURVEY PLETED
		245328	B. WING			09/21	
	PROVIDER OR SUPPLIER			28	TREET ADDRESS, CITY, STATE, ZIP CODE 3210 OLD TOWNE ROAD HISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)	) BE	(X5) COMPLETION DATE
	pipes in the humid TCU Unit,  2. the door to the not positively close 3. the Wellness sta wood working sh self-closing door let this deficient cond Maintenance Direct NFPA 101 LIFE SA Emergency lighting	ch hole and an opening around ifier room that is located in the TCU Unit soiled utility room did and latch into the frame, and torage room was converted into the and does not have a pading into the corridor.	K	029	repaired. The facility will monitor a sustain correction by completing a of 10% of all doors with closers on monthly. The results of audits will reviewed in QAA and determinatio made for continued audits.  Director of Maintenance and/or de will be responsible for ongoing compliance.	n audit them be n will be	10/15/15
	Based on observations staff, the facility has emergency lighting accordance with N and 18.2.9.1. This residents, staff and emergency evacuations include:  On facility tour betwo 09/21/2015, during emergency battery maintenance docu	is not met as evidenced by: Itions and an interview with Is failed to ensure that Is has been tested in IFPA LSC (00) Section 7.9.3, It deficient practice could It visitors in the event of an action during a power outage.  Ween 10:30 AM to 2:30 PM on It the review of available Iback up exit lighting Imentation and interview with Interctor (MC) revealed the that			All EXIT lights were tested to ensuproper function. Education was proper for all maintenance staff on how to for proper functioning of lights and regulatory guidelines. The facility monitor and sustain correction by all monthly 30 second and annual minute testing in the electronic preventative maintenance program (TELs), where they will be tracked stored.  Director of Maintenance and/or de will be responsible for ongoing compliance	ovided check will placing 90	

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	ING 0	ECONSTRUCTION 12 - THE MARGARET S. PARMLEY		E SURVEY PLETED
		245328	B. WING			09/	21/2015
	PROVIDER OR SUPPLIER RGARET S PARMLY			28	REET ADDRESS, CITY, STATE, ZIP CODE 210 OLD TOWNE ROAD HISAGO CITY, MN 55013		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 046		conduct the required Monthly and 90 minute testing of the	K	046			
K 050 SS=F	Maintenance Direct NFPA 101 LIFE SA Fire drills are held a varying conditions, The staff is familiar that drills are part of Responsibility for passigned only to conqualified to exercise conducted between	at unexpected times under at least quarterly on each shift. with procedures and is aware of established routine. Identify and conducting drills is empetent persons who are leadership. Where drills are in 9 PM and 6 AM a coded	Κ¢	)50			10/15/15
	This STANDARD is Based on review of interview, it was de to conduct fire drills Safety Code 101(0 12-month period. Taffect how staff real Improper reaction is of all residents, star Findings include:  On facility tour betw 09/21/2015, during maintenance docur	s not met as evidenced by: if reports, records and staff termined that the facility failed in accordance with NFPA Life 0), 18.7.1.2, during the last his deficient practice could ict in the event of a fire. by staff would affect the safety if and visitors of the facility.  veen 10:30 AM to 2:30 PM on the review of all available mentation and interview with irector (MC) it was revealed			Maintenance Director completed a thorough search of records and gai access to old TELs reports. Completive Drill records were found for all quarters in question. The facility with monitor and sustain compliance by placing all planned quarterly fire drifthe electronic preventative mainten program (TELs), where they will be tracked and stored.  Director of Maintenance and/or deswill be responsible for ongoing compliance.	ned leted of the ill lls in ance	

ı		TO LOW MEDIO, WE		000 1404	TIOL I	- CONCEDUCION	(X3) DAT	E SURVEY
		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ING C	E CONSTRUCTION D2 - THE MARGARET S. PARMLEY		PLETED
			245328	B. WING			09/	21/2015
		PROVIDER OR SUPPLIER			28	TREET ADDRESS, CITY, STATE, ZIP CODE 3210 OLD TOWNE ROAD HISAGO CITY, MN 55013	<u></u>	
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	K 050	drill documentation  1. a evening shift d  2. a overnight shift quarter,  3. a day shift drill in  4. a evening shift d quarter,  5. a overnight shift quarter,	d to provide the following fire	K	050			
27 Charles	K 052 SS=F	Maintenance Direct NFPA 101 LIFE SA A fire alarm system installed, tested, an with NFPA 70 Natio 72. The system has and testing program	ition was verified by the tor (MC). FETY CODE STANDARD required for life safety is an approved maintenance on complying with applicable PA 70 and 72. 9.6.1.4	K	052			10/15/15
		Based on observat	s not met as evidenced by: tion and staff interview, it was cility had failed to install and		The state of the s	Maintenance Director completed a thorough search of records and wa		

1	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ING	E CONSTRUCTION 02 - THE MARGARET S. PARMLEY E		SURVEY PLETED
		245328	B. WING		·	09/2	21/2015
	PROVIDER OR SUPPLIER	RESIDENCE	<u> </u>	2	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD HISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 052	the requirements of 18.3.4.1 and 9.6, a Sections 7.1. This adversely affect the system, and could and emergency ac	arm system in accordance with f 2000 NFPA 101, Sections s well as 1999 NFPA 72, deficient condition could functioning of the fire alarm delay the timely notification tions for the facility thus all residents, staff, and	K	052	to locate the annual testing documentation of the fire alarm systhat was completed on February 1. The facility will monitor and sustain compliance by placing all planned fire alarm testing in the electronic preventative maintenance program (TELs), where it will be tracked and stored.	0, 2015. เ annual เ	
	o9/21/2015, observerview of all available for the last 12 mon Maintenance Direct at the time of the in	veen 10:30 AM to 2:30 PM on vations and documentation ole fire alarm documentation ths, and an interview with the tor (MC), it was revealed that aspection that the facility could rent testing documentation for tem.			Director of Maintenance and/or de will be responsible for ongoing compliance.	signee	
K 054 SS=F	Maintenance Director NFPA 101 LIFE SA All required smoke activating door hold maintained, inspector	ition was verified by the for (MC). IFETY CODE STANDARD detectors, including those d-open devices, are approved, fed and tested in accordance rer's specifications. 9.6.1.3	Κ(	)54			10/15/15
	Based on staff inte	s not met as evidenced by: erview and a review of the tation, the facility has not uired sensitivity testing of the	·		Maintenance Director completed a thorough search of records and wa to locate the sensitivity testing of e	as able	

		& MEDICAID SERVICES				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 02 - THE MARGARET S. PARMLEY NCE		E SURVEY PLETED
		245328	B. WING		09/	21/2015
	PROVIDER OR SUPPLIER	RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	D BE	(X5) COMPLETIO DATE
K 054	smoke detectors or accordance with NI Code (99), Sec. 7-3 could affect all resid facility.  Findings include:  On facility tour betw 09/21/2015, a revidual arm maintenance the last 12 months, Maintenance Directime of the inspection of the reach smoke detect facility.  This deficient condimaintenance Direction of the reach smoke detect facility.  This deficient condimaintenance Direction of Spring components, device complete coverage The system is main NFPA 25, Standard and Maintenance of Systems. There is supply for the system is supply for	the fire alarm system in FPA 72 National Fire Alarm 3.2.1. This deficient practice dents, visitors, and staff of the dents, visitors, and staff of the dents of the facility's available fire and testing documentation for and an interview with the for (MC) revealed that at the for the facility could not provide entation verifying the equired sensitivity testing of for located throughout the description of the STANDARD description of the facility. The systems, with approved the systems, with approved the systems, with approved the systems of the facility. Italined in accordance with for the Inspection, Testing, if Water-Based Fire Protection a reliable, adequate water in the system is equipped temper switches which are	KO	smoke detector located througho facility that was completed on Fe 2014. The facility will monitor ar compliance by placing all require testing of the sensitivity of the sm detectors in the electronic prever maintenance program (TELs), where will be tracked and stored.  Director of Maintenance and/or divill be responsible for ongoing compliance.	oruary 5, d sustain d annual oke tative here they	10/15/15

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	NG (	02 - THE MARGARET S. PARMLEY	DATE COMP	SURVEY PLETED
	PROVIDER OR SUPPLIER		<i>5.</i> 7711.0	S'	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD HISAGO CITY, MN 55013	V312	1/2013
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	And A 1999 of A 1998 per systematics and the	(X5) COMPLETION DATE
K 056	Continued From pa	age 8	K	)56			
	Based on observation found that the autoinstalled and maint NFPA 13 the Stand Sprinkler Systems the sprinkler system (99) could allow sy causing a decrease capability in the evwould affect the refacility.  Findings include:  On facility tour bets 09/21/2015, observatorage that is local	is not met as evidenced by: itions and staff interview, it was matic sprinkler system is not tained in accordance with lard for the Installation of (99). The failure to maintain in in compliance with NFPA 13 stem being place out of service in the fire protection system ent of an emergency that sidents, visitors and staff of the ween 10:30 AlVI to 2:30 PM on vations revealed that the ited in the TCU linen room was the sprinkler deflector.			The TCU Linen Room has been clean and organized. Par levels for items we adjusted. Walls were clearly marked wered tape for staff to visualize where the cannot store items. Staff education was provided. The facility will monitor and sustain compliance by completing monaudits of the storage rooms. The result of audits will be reviewed in QAA and determination will be made for continue audits.  Director of Maintenance and/or designed will be responsible for ongoing compliance.	ere vith y is ithly its	
K 062 SS=F	Maintenance Direct NFPA 101 LIFE SA Required automatic continuously maint condition and are is	ition was verified by the tor (MC). FETY CODE STANDARD c sprinkler systems are ained in reliable operating aspected and rested 6, 4.6.12, NFPA 13, NFPA 25,	K	062			10/15/15
	This STANDARD	is not met as evidenced by:					

CENTER	19 LOW MICHICALI	E & MEDICAID SERVICES	l				CHOVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ING	E CONSTRUCTION 02 - THE MARGARET S. PARMLEY :		E SURVEY PLETED
		245328	B. WING			09/2	21/2015
	PROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD HISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 062	with staff, the facili and maintain the a accordance with N Section 18.7.6, and of Sprinkler Syster for the Inspection, Water Based Fire deficient practice of sprinkler system is fully operational in	age 9 entation review and interview ty has failed to properly inspect utomatic sprinkier system in FPA 101 Life Safety Code (00), d 4.6.12, NFPA 13 Installation ns (99), and NFPA 25 Standard Testing and Maintenance of Protection Systems, (98). This loes not ensure that the fire functioning properly and is the event of a fire and could esidents, staff and visitors.	KC	062	Maintenance Director completed a thorough search of records and wa to locate the annual fire sprinkler to was completed on February 10, 20. The facility will monitor and sustain compliance by placing all planned a fire sprinkler testing in the electronic preventative maintenance program (TELs), where it will be tracked and stored.  Director of Maintenance and/or deswill be responsible for ongoing compliance.	s able est that 15. annual cc	
K 064	09/21/2015, a revieinterview with the revealed that at the facility failed to procurrent annual fire completed.  This deficient cond Maintenance Direct NFPA 101 LIFE SAPPOrtable fire exting health care occupated 9.7.4.1, NFPA 10.	wishers are provided in all ancies in accordance with 18.3.5.6	ĸc	064			10/15/15
CONNECTOR TO PERSON ASSOCIATION		is not met as evidenced by: entation review and staff			Monthly fire extinguisher inspectio	ns will	

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			O.	AID IAO.	0930-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		DING	E CONSTRUCTION 02 - THE MARGARET S. PARMLEY :		SURVEY PLETED
		245328	B. WING	·		09/2	21/2015
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	!	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE MAI	RGARET S PARMLY I	RESIDENCE			8210 OLD TOWNE ROAD HISAGO CITY, MN 55013		
					PROVIDER'S PLAN OF CORRECTION	M	(X5)
 (X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
K 064	to maintain portable accordance with N 9.7.4.1 and NFPA could affect all resifacility.  Findings include:  On facility tour betw 09/21/2015, the resimonthly inspection months and observialled to conduct 3	age 10 stermined that the facility failed of fire extinguishers in FPA 101-2000 edition, Section 10. This deficient practice dents, staff and visitors of the view of the fire extinguisher documentation for the past 12 vation revealed, that the facility monthly inspections of the fire are located throughout the	K	064	be completed timely. The facility we monitor and sustain compliance by scheduling all fire extinguisher inspirit the electronic preventative maining program (TELs), where it will be trained stored. Monthly audits will be completed on 5 extinguishers per in the results of audits will be review QAA and determination will be made continued audits.  Director of Maintenance and/or desired will be responsible for ongoing compliance.	pections tenance acked month. ed in de for	
K 067 SS=F	Maintenance Direct NFPA 101 LIFE SA Heating, ventilating with the provisions in accordance with specifications. 9 90A	ition was verified by the tor (MC). FETY CODE STANDARD  If, and air conditioning comply of section 9.2 and are installed the manufacturer's .2, 18.5.2.1, 18.5.2.2, NFPA	K	067			10/15/15
	Based on docume interview, the fire/s been maintained in requirements of Notice deficient practice deficient practice.	is not met as evidenced by: Intation review and staff Imoke damper system has not Inaccordance with the IPA 90(99) section 3-4.7. This Income not ensure the proper Income sand could			Maintenance Director completed a thorough search of records and was to locate the annual damper testing document that was completed on February 10, 2015. The facility will monitor and sustain compliance by	as able g I	

RS FOR MEDICARE	: & MEDICAID SERVICES				OIVID IVO.	0930-039
OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	ING <b>02 -</b>		(X3) DAT COM	E SURVEY PLETED
	245328	B. WING			09/	21/2015
PROVIDER OR SUPPLIER	1			•		
RGARET S PARMLY	RESIDENCE					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION DATE
allow smoke migra	tion to negatively affect the	KC	pl el pr	ectronic preventative maintena rogram (TELs), where it will be	nce	
Findings include:  On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Maintenance Director (MC), that the facility had failed to provide documentation verifying that the tire and smoke dampers have been tested/inspected within the last 4 years.			w	ill be responsible for ongoing	esignee	
Maintenance Direct NFPA 101 LIFE SA Soiled linen or trast exceed 32 gal (121 density of containe does not exceed .5 capacity of 32 gal (any 64 sq ft (5.9 sq or trash collection rigreater than 32 gal protected as a haza	tor (MC).  FETY CODE STANDARD  In collection receptacles do not L) in capacity. The average r capacity in a room or space gal/sq. ft (20.4 L/sq m). A 121 L) is not exceeded within m) area. Mobile soiled linen receptacles with capacities (121 L) are located in a room argous area when not	ΚC	075			10/15/15
	PROVIDER OR SUPPLIER  RGARET S PARMILY I  SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From pa allow smoke migra safety of all resider event of a fire.  Findings include:  On facility tour betw 09/21/2015, it was the facility's fire and test/inspection doc by interview with th that the facility had documentation veri dampers have bee last 4 years.  This deficient cond Maintenance Direct NFPA 101 LIFE SA  Soiled linen or trast exceed 32 gal (121 density of containe does not exceed .5 capacity of 32 gal ( any 64 sq ft (5.9 sq or trash collection r greater than 32 gal protected as a haza	PROVIDER OR SUPPLIER  RGARET S PARMLY RESIDENCE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 11 allow smoke migration to negatively affect the safety of all residents, staff and visitors in the event of a fire.  Findings include:  On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Maintenance Director (MC), that the facility had failed to provide documentation verifying that the tire and smoke dampers have been tested/inspected within the last 4 years.  This deficient condition was verified by the Maintenance Director (MC).  NFPA 101 LIFE SAFETY CODE STANDARD  Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq. fr (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq fr (5.9 sq. m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not	TOF DEFICIENCIES DE CORRECTION  (X1) PROVIDER/SUPPLIER/CATION NUMBER: 245328  PROVIDER OR SUPPLIER  RGARET S PARMLY RESIDENCE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 11  allow smoke migration to negatively affect the safety of all residents, staff and visitors in the event of a fire.  Findings include:  On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Maintenance Director (MC), that the facility had failed to provide documentation verifying that the tire and smoke dampers have been tested/inspected within the last 4 years.  This deficient condition was verified by the Maintenance Director (MC). NFPA 101 LIFE SAFETY CODE STANDARD  Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq. ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9 sq. m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not	TOF DEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER/CIA A BUILDING 02-RESIDENCE  245328  PROVIDER OR SUPPLIER  RGARET S PARMLY RESIDENCE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 11  allow smoke migration to negatively affect the safety of all residents, staff and visitors in the event of a fire.  Findings include:  On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Maintenance Director (MC), that the facility had failed to provide documentation verifying that the fire and smoke dampers have been tested/inspected within the last 4 years.  This deficient condition was verified by the Maintenance Director (MC).  NFPA 101 LIFE SAFETY CODE STANDARD  K 075  Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq. ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9 sq. m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not	TOP DEFICIENCIES PEORRECTION  (X1) PROVIDER/SUPPLIER 245328  PROVIDER OR SUPPLIER  RGARET S PARMLY RESIDENCE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LOC IDENTIFYING INFORMATION)  Continued From page 11  allow smoke migration to negatively affect the safety of all residents, staff and visitors in the event of a fire  On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Maintenance Director (MC), that the facility had failed to provide documentation verifying that the lire and smoke dampers have been tested/inspected within the last 4 years.  This deficient condition was verified by the Maintenance Director (MC).  NFPA 101 LIFE SAFETY CODE S'TANDARD  Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average does not exceed 3.5 gal/sq. ñ (20.4 L/sq m). A capacity of 32 gal (121 L) in capacity. The average does not exceed 3.5 gal/sq. ñ (20.4 L/sq m). A capacity of 3.2 gal (121 L) are located in a room protected as a hazaratous area when not	TOP DEFICIENCIES  (X1) PROVIDER SUPPLIER CALL  (X2) AULTIPLE CONSTRUCTION  245328  THE MARGARET S. PARMLEY  245328  STREET ADDRESS, CITY, STATE, ZIP CODE  2210 OLD TOWNE ROAD  CHISAGO CITY, MN 55013  COMPETED TOWNER OF DEFICIENCIES  (EACH DEFICIENCY MIST BE PRECEDED BY FULL  REGULATORY OR LSC (DENTIFYING INFORMATION)  COntinued From page 11  allow smoke migration to negatively affect the safety of all residents, staff and visitors in the event of a fire.  Con facility four between 10:30 AM to 2:30 PM on 09/21/2015, it was revealed during the review of the facility's fire and smoke damper testinspection documentation and was confirmed by interview with the Maintenance Director (MC), that the facility had failed to provide documentation verifying that the like and smoke dampers have been tested/inspected within the last 4 years.  This deficient condition was verified by the Maintenance Director (MC).  NFPA 101 LIFE SAFETY CODE STANDARD  Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed. 5 gal/sq. ft (20 4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq. ft (6.9 sq. m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazarroous area when not

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	ING	02 - THE MARGARET S. PARMLEY		SURVEY PLETED
		245328	B. WING			09/2	21/2015
	ROVIDER OR SUPPLIER	RESIDENCE		2	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD HISAGO CITY, MN 55013		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 075	Based on observated facility has failed to carts in properly provided by the NFPA 101 edition (LSC) section practice could affect staff and visitors if these carts rendered by the soiled utility room utiple mobile soil that are greater that spaces that are greater) and that are greater) and that are greater area.	is not met as evidenced by: tions and staff interview, the store large trash and linen otected rooms in accordance "The Life Safety Code" 2000 on 19.7.5.5. This deficient of the safety of all residents, smoke or fire from one of ed the corridors untenable.  In the facility was storing of linen and trash container on 32 gallons in aggregate in eater than 64 square feet (in open to the corridors and not in clous storage areas.	K	075	Staff were educated on October 6 a 2015 on proper use and storage of linen and trash receptacles. To more compliance, environmental services conduct observational audits for so linen and trash daily x 2 weeks, the weekly x4 weeks, and finally month. The Quality Assurance Performance Improvement (QAPI) will determine discontinuation of audits is indicated current practice has been deemed is sustained and compliant.  Director of Maintenance and/or des will be responsible for ongoing compliance.	soiled nitor s will iiled n ly e if d once to be	,
K 144 SS=F	Maintenance Direc NFPA 101 LIFE SA Generators are ins	FETY CODE STANDARD  pected weekly and exercised  ninutes per month in	<b>K</b> 1	44			10/15/15
	This STANDARD	s not met as evidenced by:					

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ING	E CONSTRUCTION 02 - THE MARGARET S. PARMLEY :	СОМІ	E SURVEY PLETED 21/2015
	PROVIDER OR SUPPLIER		D. 74110	S' 2	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD HISAGO CITY, MN 55013	1 0912	. I/20 IJ
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
K 154 SS=F	Based on docume interview, the facility generators in according of 2000 NFPA 101 6-4.2 (a) & (b) and could affect all restacility.  Findings include:  On facility tour betwo9/21/2015, documentation for testing of the emeron documentation for testing of the emeron NFPA 101 LIFE SAWhere a required to out of service for in period, the authority and the building is watch system is prunprotected by the	entation review and staff ty failed to test the emergency ordance with the requirements - 9.1.3 and 1999 NFPA 110 6-4.2.2. The deficient practice idents, staff, and visitors of the ween 10:30 AM to 2:30 PM on mentation review of the ator testing logs indicated that of locate or provide any of the weekly or monthly regency power generator.  lition was verified by the		154	Weekly and monthly generator test currently being completed and logg Maintenance staff were educated to complete the tests. The Policy a Procedure for generator testing was reviewed and is current. The facility monitor and sustain compliance by completing monthly audits of generatest log. The results of audits will be reviewed in QAA and determination made for continued audits.  Director of Maintenance and/or deswill be responsible for ongoing compliance.	ged. on how and as ty will rator oe n will be	10/15/15
	Based on a record facility has failed to acceptable written be followed in the	is not met as evidenced by: If review and staff interview, the If provide a complete and If policy containing procedures to If event that the automatic fire If as to be placed out-of-service			Maintenance Director completed a thorough search of records and wa to locate the Automatic Fire Sprink System Out of Service Policy. The was reviewed and is accurate.	as able ler	

CENTL	NO FOR MILDIONIA	A MEDICAID SERVICES	T			********	0000 000 1
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ING	E CONSTRUCTION 02 - THE MARGARET S. PARMLEY E		E SURVEY PLETED
		245328	B, WING			09/2	21/2015
	PROVIDER OR SUPPLIER	RESIDENCE		2	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 154	deficient practice c for early response	urs in a 24 hour period. This ould affect the facility's ability and notification of a fire and fety of all residents, visitors	K.	154	Director of Maintenance and/or des will be responsible for ongoing compliance.	ignee	
	09/21/2015, during interview with the father the facility cou	veen 10:30 AM to 2:30 PM on record review and an acility manager, it was found ld not provide a complete kler system out of service					
K 155 SS=F	Maintenance Director NFPA 101 LIFE SA  Where a required if service for more that the authority having building is evacuate provided for all par	FETY CODE STANDARD  are alarm system is out of an 4 nours in a 24-hour period, p jurisdiction is notified, and the ed or an approved fire watch is ties left unprotected by the fire alarm system has been	K	155			10/15/15
	Based on a record facility has failed to acceptable written be followed in the salarm system has the four or more hours	s not met as evidenced by: review and staff interview, the provide a complete and policy containing procedures to event that the automatic fire to be placed out-of-service for in a 24 hour period. This could affect the facility's ability	The state of the s		Maintenance Director completed a thorough search of records and wa to locate the Automatic Fire Alarm S Out of Service Policy. The policy w reviewed and is accurate.  Director of Maintenance and/or des	s able System /as	

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ING	E CONSTRUCTION 02 - THE MARGARET S. PARMLEY :	(X3) DATI COM	E SURVEY PLETED
		245328	B. WING			09/	21/2015
1	PROVIDER OR SUPPLIER		<u> </u>	2	TREET ADDRESS, CITY, STATE, ZIP CODE 8210 OLD TOWNE ROAD HISAGO CITY, MN 55013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL AS DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETION DATE
K 155	for early response	and notification of a fire and afety of all residents, visitors	K.	155	will be responsible for ongoing compliance.		NAMANIANA NAMANA NA
	07/14/2015, during interview with the that the facility coulautomatic fire alar	ween 1:30 PM and 3:30 PM on a record review and an facility manager, it was found ald not provide a complete in system out of service policy.  Itice was verified by the Facility					



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted October 5, 2015

Ms. Julie Spiers, Administrator The Margaret S Parmly Residence 28210 Old Towne Road Chisago City, Minnesota 55013

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5238023

Dear Ms. Spiers:

The above facility was surveyed on September 14, 2015 through September 17, 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.

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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

The Margaret S Parmly Residence October 5, 2015 Page 2

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 immediately contact Gayle Lantto at 651-201-3794.

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, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 10/30/2015 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00065 09/17/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD THE MARGARET S PARMLY RESIDENCE CHISAGO CITY, MN 55013 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 \*\*\*\*\*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

**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/inf obul.htm The State licensing orders are delineated on the attached Minnesota

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.

Minnesota Department of Health

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

TITLE

(X6) DATE

Electronically Signed

10/15/15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	<del></del>		
		00065	B. WING		09/17/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
THE MA	RGARET S PARMLY F	RESIDENCE	D TOWNE R			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
2 000	Continued From pa	ige 1	2 000			
	Department of Hea you electronically, is necessary for Sta enter the word "context. You must then State licensure procompletion date, the corrected prior to e Minnesota Department's staff, the following correction that you and identify the date.  Minnesota Department of Heave indicate in your correction that you and identify the date.	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the				
	The assigned tag n column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. The findings which are it after the statement evidence by." Followare the Suggested Time period for Correction order. The statement evidence by." Followare the Suggested Time period for Correction PLEASE DISREGATION FOUNTH COLUMN "PROVIDER'S PLATING APPLIES TO FEDE	ARD THE HEADING OF THE				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
			A. BUILDING.			
		00065	B. WING		09/1	7/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE MAR	RGARET S PARMLY F	RESIDENCE	D TOWNE R CITY, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.					
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			10/15/15
		omprehensive plan of care I personnel involved in the i.				
	by: Based on observative review, facility failed eating and reposition	ent is not met as evidenced fon, interview, and document d to provide assistance with oning in accordance with care lent (R16) reviewed for		Corrected		
	Findings include:					
	8:23 a.m. to 8:37 a -At 8:23 a.m. R16 v of the bed elevated was covering R16's it. R16 brought a sp spilling half (1/2) of stated "I can't feed -At 8:28 a.m. NA-B "Hospice feeds you breakfast." -At 8:37 a.m. R16 h	observation on 9/15/15, from the ware as follows: was lying in bed with the head to 45 degrees. A white cloth is chest with oatmeal spilled on boonful of oatmeal to mouth the teaspoon on chest. R16 myself I spill everything." was overheard informing R16, if for lunch, you feed yourself and a covered cup with a spout e on tray. R16 was able to lift				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00065		B. WING		09/	17/2015
NAME OF	PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
THE MA	RGARET S PARMLY F	RESIDENCE		O TOWNE RO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCI MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 565	Continued From pacup to mouth very schest was observed of oatmeal on the workst. When appropriate appr	slowly. At the same a with one third of Rahite cloth that cover ached R16 stated to hey say they are too observation on 9/160 a.m. were as follows still seated in what table. R16 stated it. fast trays arrived in itting in room, tray the eakfast tray had not took tray in to R16's was heard ask NA-And breakfast?" NA-And help you if I have the of the trays and ger front of the table whom trays had been provided how was brown asked how was brown asked how was brown to eat, but she nevel and I spill on myself. But a quarter of cup of the country and the country and the country and the country are sident is requesting the sist most meals."	16's bowl red the surveyor, busy."  /15, from ws: neelchair in was unit on able in the been someone ith the tray bassed. Pakfast? have been y brought came I hate it removed reent of hot of milk.	2 565			

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
		00065	B. WING		00/1	7/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 09/1	7/2013
		28210 OLI	D TOWNE R			
THE MA	RGARET S PARMLY F	RESIDENCE	CITY, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 4	2 565			
	extensive assistanc	ce of 1 staff to eat."				
	9/16/15, include but (difficulty swallowing disease (stroke), m depression, fatigue  Undated/unlabeled sheet for R16 indicated of the indicate	Nursing Assistant Assignment ated, "Assist of 1 for all ADLs."  5 a.m. RN-B stated "If [R16] they are to help her or at least coses to eat in room. [R16] is ing, if eats in room, [R16] may reelf. People who need the dining room. It is difficult they are good and some days cause of [R16's] tremor. We spice aide to feed her lunch. visit with [R16] eating in the needs help eating. Trays are				
	On 9/17/15 at 11:23 (DON) stated, "My oresident asks for he tremor and may new Sometimes she need of it herself." She rextensive assistance not have to ask for this." When asked if the assistance and replied, "No. I will be report on this." Policy for providing requested from facing Repositioning:	B a.m. director of nursing expectation is anytime a selp you help them. She has a sed help. It is on and off. eds help sometimes she can equires per care plan se of one to eat. "She should assistance to eat based on if your staff providing her with cares she needs? DON e filing a vulnerable adult assistance with eating was sility but not provided.				

Minnesota Department of Health

STATE FORM 5699 ZNE511 If continuation sheet 5 of 39

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00065	B. WING		09/	17/2015
	NAME OF PROVIDER OR SUPPLIER  THE MARGARET S PARMLY RESIDENCE  28210 OI CHISAGE					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 565	7:08 a.m. until 11:00 -7:08 a.m. R16 up i combed7:35 a.m. R16 sittii -7:50 a.m. R16 sittii -8:28 a.m. NA-A too did not reposition R169:09 a.m. R16 whe bed9:15 a.m. RN-A tall -9:33 a.m. RN-A sti unchanged9:44 a.m. the beau shop9:54 a.m. R16 sittii closed. There was a that was approximadid not shift buttock -10:13 a.m. R16 sitti not changed position -10:53 a.m. R16 sittinot changed position -11:00 a.m. R16 sittinot changed position -10:53 a.m. the bear and changed position -11:00 a.m. R16 sittinot changed position -10:53 a.m. the bear approximately five of side of center. No Condition of the condi	0 a.m. n wheelchair getting her hair ng in wheel chair. ng waiting for breakfast. ok tray in to R16 room. NA-A 116. oked up tray. RN-B did not eeled herself slowly toward he king with R16 in R16's room. Il in room. R16's position utician took R16 to the beauty ng in wheelchair with her eyes a cushion in the wheelchair ately three inches thick. R16 is. ting under the drier. R16 had	s k			

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

AND DUAN OF CORRECTION					DATE SURVEY COMPLETED	
		00065	B. WING		09/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE MAI	RGARET S PARMLY F	RESIDENCE	D TOWNE R			
			CITY, MN 5		ON!	0.5
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
2 565	Continued From pa	ge 6	2 565			
	Diagnosis for R16 from Admission Record dated 9/16/15, include but not limited to other late effects of cerebrovascular disease (stroke), muscle weakness, major depression, fatigue and anxiety.					
	R16's care plan for "decreased physical mobility with potential for falls and impaired skin r/t dx of DJD [degenerative joint disease], chronic pain m/b [manifested/by] inability to transfer, ambulate, wheel self, turn/reposition" printed on 9/16/15, indicated "Turn and reposition resident every 2 hours and PRN [as needed] using pillows."					
	Undated/unlabeled "nursing assistant assignment sheet" for R16 indicated, "Reposition Q[every] 2H [hour]) using pillows" and "turn and Reposition resident frequently-AT LEAST Q2H."					
	On 9/16/15, at 10:23 a.m. beautician stated, "[R16] gets her hair done weekly at the same time every week. The aides do not check on the residents unless I call them and say there is a problem. I come and get the residents and bring them back."  On 9/16/15, at 10:56 a.m. RN-B stated, R16 did not usually get out of bed. R16 was able to tell us when needed help. R16 was to be repositioned every two hours.					
	skin was red but bla blanchable pressur infection that we are and more absorber expectation for repo	5 a.m. RN-B stated, R16's anchable there were no non e areas. She has a fungal e treating with Nystatin cream at brief. RN-B stated "my ositioning is if there is a current y one hour, otherwise at least rs."				

Minnesota Department of Health

STATE FORM 5699 ZNE511 If continuation sheet 7 of 39

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
7.1.12 . 2.11.	o. co2011		A. BUILDING:		OOMI EETED		
		00065	B. WING		09/1	7/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE MAI	RGARET S PARMLY F	RESIDENCE	D TOWNE R CITY, MN 5				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE	
2 565	Continued From pa	ge 7	2 565				
	expectation was [R just did this enormore and pressure ulcer asked [R16] to offlow would be at risk for we have alternating w/c but [R16] still not asked are your staff assistance and care replied, "No. I will be report on this."  SUGGESTED MET The DON or design policies and procedure plan for each in the director of nursidevelop a system to monitoring system in the director of s	3 a.m. the DON stated, "the 16] has to be offloaded. We ous education on repositioning prevention. We could have ad and offered to help. [R16] pressure ulcers, that is why air mattress and cushion in eeds to be off loaded." When f providing her with the es she needs? DON e filing a vulnerable adult  THOD OF CORRECTION: nee (s)could review and revise dures related to ensuring the individual resident is followed. Sing or designee (s)could be educate staff and develop a to ensure staff are providing					
	care as directed by the written plan of care.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days.						
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision  Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of		2 570			10/15/15	

Minnesota Department of Health

STATE FORM 5699 ZNE511 If continuation sheet 8 of 39

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00065	B. WING		09/1	17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
THE MAI	RGARET S PARMLY F	RESIDENCE	OLD TOWNE F			
	OLIMANA DV. OTA		GO CITY, MN		FION	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 8	2 570			
	the comprehensive by part 4658.0400,	resident assessment requir subpart 3, item B.	ed			
	by: Based on observati review, facility failed	ent is not met as evidenced on, interview and document d to update the care plan aftent ent (R21) reviewed for		Corrected		
	Findings include:					
	On 9/14/15, at 5:01 p.m. R21 was observed sitting in a wheelchair in the dining room. R21 had half-moon shaped faint green blue bruising under both eyes, had a laceration in the middle of forehead and left arm was noted to be in a sling.		er			
	was interviewed and prevent R21 from fa [R21] a lot, provide her. [R21] likes to s	p.m. nursing assistant (NA) d when asked what she did alling NA-I stated "I talk to distractions, spend time with tack things. Therapy is Walking would benefit her. and up on her own."	to			
	I	a.m. was interviewed and e easily, I must have fallen."				
	potential for injury ( physical mobility, co medication use. The included adjust bed socks, assist of for assistive devices as precautions PRN, to call light within read	red 8/18/15, indicated R21 h falls) related to impaired ognitive impairment, e care plan interventions to appropriate height, gripp all transfers/ ambulation, s needed (PRN), fall ransfer belt with all transfers th, remind every shift to call eft unattended in bathroom.	er			

Minnesota Department of Health

Minnesota Department of Health

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
			A. BOILDING.			
		00065	B. WING		09/	17/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE MAI	RGARET S PARMLY F	RESIDENCE	D TOWNE R CITY, MN 5			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETE DATE
2 570	Continued From pa	age 9	2 570			
	following noted R2: 8/29/15, and 9/6/15 had been develope which two had sign had not been upda: The falls were as for Confidential Peer Incident Report dat was found sitting or had sustained a sk and a 12 centimete to the left forearm. immediate interven further falls were, to monitoring to estable bowel and bladder different wheelchair were done. R21 did labs had been com care planned to be facility did not deve individualized prografter the fall.  -Confidential Peer Incident Report dat	ard was reviewed and the 1 had fallen on 8/23/15, 5. Even though interventions of following each of the falls of ificant injuries R21's care planted to reflect the interventions. Sollows: Review Document Resident and 8/23/15, indicated, R21 and floor of the dining room and in tear on the left index finger for (cm) long by 4 cm deep gash. The report indicated tions implemented to prevent to continue bowel and bladder of solish patterns to develop a program, R21 was given a rand labs for baseline status of receive a new w/c and the pleted. Even though R21 was toileted every two hours, the slop and implement and ram for bowel and bladder receive Document Resident and Review Doc				
	injury indicated. Th implemented were, (PT) and occupation wheelchair position or doctor was to relevation. The med had checked the blaceived PT/OT, the reflect the therapies	e report indicated interventions to continue physical therapy and therapy (OT) to address ing and the nurse practitioner view blood pressure's due to lical review noted the physician ood pressures. Although, R21 e care plan was not revised to				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00065	B. WING		09/1	7/2015
	PROVIDER OR SUPPLIER	RESIDENCE 28210 OL	DRESS, CITY, S D TOWNE R			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 570	Incident Report dat witnessed bending Martha's dining roo the head. R21 had and large bump to report interventions assess R21 for a til for vision field cut a R21 on safety and with R21 on balanc R21 received OT, t any information reg field cut. The tilt and the plan of care.  R21's diagnoses in hypertension, other retinal degeneration obtained from the a (MDS) dated 8/25/1 R21 was severely crequired assistance (ADL). In addition the fallen since admiss and had a fracture months prior to admission to be updated. RN-not been updated wadmission and eventwo significant injur facility.	ed 9/6/15, indicated, R21 was over reaching to the floor in m and fell to the floor hitting sustained a 3 cm laceration forehead with bruising. The implemented were for OT to t in space wheelchair, assess and to continue to work with PT was to continue to work e and strengthening. Although the medical record was void of arding the assessment of the dispace w/c was not added to cluded dementia, fracture, lumbago, peripheral and difficulty walking admission Minimum Data Set 15. The MDS also indicated cognitively impaired and with activities of daily living the MDS indicated R21 had ion or the prior assessment related to a fall in the six mission.  a.m. registered nurse (RN)-C iewed by the interdisciplinary indicated after a progress note of the care plan was supposed C verified the care plan had with new fall interventions since in though R21 had sustained ies since admission at the	2 570			
	October 2010 direc	ehensive policy revised ted staff: comprehensive care plan that				

6899

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY PLETED
ANDILAN	OF CONTILOTION	IDENTIFICATION NO	JIVIDEI (.	A. BUILDING:		OOWII	LLILD
		00065		B. WING		09/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE MAI	RGARET S PARMLY F	RESIDENCE		D TOWNE R CITY, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 570 2 625	includes measurab meet the resident's psychological need resident " In add " 8. Assessments of care plans are revisive resident's condition SUGGESTED MET The director of nurs review/revise policity of care plans, educensure compliance	le objectives and time medical, nursing, medical, nursing, medical, nursing, medical, nursing, medical for exidents are ongoined as information and change"  THOD OF CORRECTION: The ate staff and performation and performation of the ate staff and performation.	nental and ach ated: oing and bout the TION: nee could e revision m audits to wenty One	2 570			10/15/15
	Subpart 1. In gerecord, including n A. the condition admission; B. temperature pressure, according subpart 2, item C. the resident according to part 4 D. the resident and attitudes; E. observations interventions providing responsible	neral. Each resident ursing notes, must in of the resident at the pulse, respiration, to part 4658.0520, I; is height and weight 658.0520, subpart 2 is general condition, as, assessments, and led by all disciplines resident, with the extractions with	at's clinical nclude: ne time of and blood , 2, item J; actions,				

Minnesota Department of Health

STATE FORM 56899 ZNE511 If continuation sheet 12 of 39

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00065	B. WING		09/1	7/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE MA	RGARET S PARMLY F	28210 OL	D TOWNE R	OAD		
THE WA	NGANET 3 PANIVILT P	CHISAGO	CITY, MN 5	55013		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 625	F. significant of behavior, orientation nursing home, G. date, time, of method of administ the signature of persons who admir H. a report of athree months prior in part 4658.08 I. reports of lab J. dates and tindressings; K. dates and tindressings; K. dates and tindressings; K. dates and tindressings; K. dates and tindressings; Comprehensive pla N. any orders of comprehensive pla N. any change habits or appetite; O. pertinent factoresident's general of P. results of the resident assessment.	oservations on, for example, in, adjustment to the judgment, or moods; quantity of dosage, and ration of all medications, and if the nurse or authorized histered the medication; a tuberculin test within the to admission, as described 10; horatory examinations; hes of all treatments and hes of visits by all licensed oners; cs or hospitals; or instructions relative to the n of care; in the resident's sleeping	2 625			
	by:	ent is not met as evidenced g 0514, Regulation FF09		Corrected		
	failed to maintain a complete for 5 of 5 R127, R197) and 2	and record review, the facility ccurate medical records were residents (R32, R81, R41, of 2 discharged residents d for monthly pharmacist				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

(X3) DATE SURVEY COMPLETED

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE MARGARET S PARMLY RESIDENCE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013								
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE				
2 625	Continued From page 13	2 625						
	Findings include:							
	Current Residents: R32's diagnoses included depressive disorder, Insomnia, hypertension, failure to thrive, congestive heart failure, atrial fibrillation, polymyalgia rheumatica and Hypopotassemia obtained from Admission Record dated 9/17/15. R32 was admitted 4/19/14. There was no consultant pharmacist's Medication Regimen Review recorded by the pharmacist for March 2015, through September 2015 in R32's chart.							
	Review of the Consultant Pharmacist's Parmly Lifepointes Summary Reports kept in a binder in the director of nursing office dated 3/4/15, 4/2/15, 5/1/15, 6/2/15, 7/2/15, 8/4/15, and 9/1/15, indicated each monthly review was inclusive for all facility residents along with any pertinent recommendations. In addition of the seven months reviewed there were six noted irregularities and/or recommendations for R32.							
	R81's diagnoses included paralysis agitans, diabetes without complications type II, rheumatoid arthritis, chronic kidney disease stage III and depressive disorder obtained from the Physician Order Report dated 9/14/15.							
	R81 was admitted 7/30/15. There was no consultant pharmacist's Medication Regimen Review recorded by the pharmacist for August 2015, in R81's chart.							
	Review of a Consultant Pharmacist's Parmly Lifepointes Summary Reports kept in a binder in the nursing office dated 8/4/15, indicated the							

Minnesota Department of Health

STATE FORM 5899 ZNE511 If continuation sheet 14 of 39

Minnesota Department of Health

	(X3) DATE SURVEY COMPLETED	
00065 B. WING 09/17/	7/2015	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
THE MARGARET S PARMLY RESIDENCE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)    Comparison of the provider's plan of correction (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 625  Continued From page 14 review was inclusive for all facility residents along with any pertinent recommendations. In addition on the 8/4/15, review a noted irregularity and/or recommendation had been identified for R81.  Sass, Kathy R41's diagnoses included alzheimer's disease, congestive heart failure, diabetes and hypertension obtained from the Admission Record printed 9/17/15.  R41 was admitted 9/27/14. There was no consultant pharmacist's Medication Regimen Review recorded by the pharmacist for each month from October 2014 thru September 2015 in R41's chart.  Review of the Consultant Pharmacist's Parmly Lifepointes Summary Reports kept in a binder in the nursing office dated 10/2/14 thru 9/1/15, indicated each monthly review was inclusive for all facility residents along with any pertinent recommendations. Five of the twelve months, 11/4/14, 1/5/15, 2/3/15, 4/2/15 and 9/1/15, noted irregularities and/or recommendations for R41.  Wong, Becky R127's diagnoses included Alzheimer disease, epilepsy, anxiety, insomnia, delusional disorder, and explosive personality disorder obtained from Admission Record dated 9/17/15. R127 was admitted 12/6/13. There was no consultant pharmacist's Medication Regimen Review available in the medical record for October 2014, December 2014, January 2015,		

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		00065	B. WING	·····	09/	17/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS CITY S	STATE, ZIP CODE	•	
10 10 201	THO VIDEN ON OUT FIELD		LD TOWNE R			
THE MA	RGARET S PARMLY F	RESIDENCE	O CITY, MN 5			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE DATE
2 625	Continued From pa	ge 15	2 625			
	Lifepointes Summathe director of nursi 5/1/15, 6/2/15, 7/2/indicated each morall facility residents recommendations. months reviewed thirregularities and/or There were no consumedication Regime pharmacist in R127 R197's diagnoses in dementia with behas polymyalgia rheumatobtained from Admit R197 was admitted consultant pharmacist exiew available in October 2014, Dece February 2015, Mar 2015 and June 201 Review of the Consultant pharmathe director of nursi showed four irreguladdress during med On 9/17/15, at 9:00 multi-patient month cannot be placed in records because the names. The blank and Pharmacy Services Reviews form was if File (white 3 ring bit at the facility. DISCHARGED RESIDES R99's diagnoses in the service of the consultant pharmacy Services Reviews form was in the facility.	ry Reports kept in a binder in ng office dated 3/4/15, 4/2/15, 15, 8/4/15, and 9/1/15, athly review was inclusive for along with any pertinent. In addition of the seven here were four noted recommendations for R127. Sultant pharmacist's in Review recorded by the reschart.  Included Alzheimer disease, avioral disturbances, atica, and neuropathy, ission Record dated 9/17/15. 8/4/15. There was no sist's Medication Regimen the medical record for ember 2014, January 2015, rch 2015, April 2015, May 5, July 2015, August 2015. Sultant Pharmacist's Parmly ry Reports kept in a binder in ng office dated 8/2015, arities for the doctor to dication reconciliation.  a.m. the DON received the ly medication reviews, they in the individual patient medical ey contain other patients and undated Thrifty White Monthly Medication Regiment in the Consultant Pharmacist ander), but was not being used				

6899

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
				A. BOILDING.				
		00065		B. WING		09/	17/2015	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE MA	RGARET S PARMLY F	RESIDENCE		D TOWNE R CITY, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICII / MUST BE PRECEDI SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
2 625	Continued From pa	ge 16		2 625				
	obtained from Admission Record dated 9/17/15.		ated 9/17/15.					
	R99 was admitted to remained in the fact Parmly Lifepointes the last consultant pedical record was consultant pharmace. Review recorded by in R99's chart.	ility until 7/5/15. Summary Repo pharmacist revie dated 6/2/15. T cist's Medication	Review of rts, indicated ew in the There was no Regimen					
	R70's diagnoses in disorder, insomnia, and cerebrovascula physician order rec	osteoporosis, h ar disease obtair	ypertension, ned from					
	R70 was admitted to remained in the fact Parmly Lifepointes the last consultant pmedical record was consultant pharmace. Review recorded by 2015, or June 2015	ility until 6/8/15. Summary Repo pharmacist revies dated 6/2/15. Toist's Medication y the pharmacis	Review of rts, indicated ew in the There was no Regimen					
	On 9/17/15, at 3:44 called no answer.	p.m. the consu	ltant was					
	On 9/17/15, at 11:0 verified that monthl be in the individual charts, but have no pharmacist took ov	y medication rev charts, and use t been since the	views should d to be in the					
	On 9/17/15, at 3:44 the consultant Phare 1:30 p.m. the CP resummary is collated electronically and e	macist (CP). Or turned the call a d onto a comput	n 9/18/15, at and stated the er form,					

Minnesota Department of Health

STATE FORM 5699 ZNE511 If continuation sheet 17 of 39

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		o	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		00065	B. WING		09/	17/2015
	PROVIDER OR SUPPLIER	RESIDENCE 282	REET ADDRESS, CITY, S 210 OLD TOWNE R ISAGO CITY, MN 5	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 625	director of nursing, been vetted by his of the monthly medical individual residents summary.  The monthly medical produced and main system and was not individual residents was provided a cope consultant pharmacinformation of multiting reviews, the consulting facility twice a monthly reviews. To monthly medication months would involute months would involute month to find the received facility twice a monthly medication months would involute months would involute month to find the received facility recommendations, number varied by recommendations, number varied by revaluating the residuating the residuating the residuating the residuating the residuation of the highest practical prevents or minimizated to medication recommendations and the atternation and the atternation and the atternation and the atternation  The facility lacked to the monthly medication for the medication for the medication for the facility lacked to monthly medication for the medication for the facility lacked to monthly medication for the medication for the facility lacked to monthly medication for the facility lacked to medication for the facility lacked to monthly medication for	and that this process had director. The CP verified ation review was not in ear chart, since it was a coll ation review information tained on a pharmacy bat available within each medical record. The DO by of each visit by the cist. The form contained ple patients monthly chat tant pharmacist visited the process of the p	that ach ated was ased N the rt ne ients ts per ges a ation ains nd es or of			
	medication reviews	available in the individua in the closed medical red				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE S COMPL	
			A. BUILDING:			
		00065	B. WING		09/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
THE MAI	RGARET S PARMLY F	RESIDENCE	D TOWNE R CITY, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 625	Continued From pa	ge 18	2 625	,		
2 020	SUGGESTED MET The DON and/or de assure the mainten and organized clinic resident. The DON perform audits of re	THOD FOR CORRECTION: esignee could monitor to ance of accurate, complete, cal information about each or designee could also esident records and report ity assurance committee.	2 020			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			10/15/15
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident in bed.				
	by: Based on observati review, failed to pro-	ent is not met as evidenced fon, interview, and document ovide assistance with eating R16) who was reviewed for		Corrected		

6899

Minnesota Department of Health

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		00065	B. WING		09/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE MAI	RGARET S PARMLY F	RESIDENCE	D TOWNE R CITY, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 19	2 830			
	R16 was observed	on 9/15/15, and 9/16/15, and requested assistance to eat				
	8:23 a.m. to 8:37 a.  -At 8:23 a.m. R16 wof the bed elevated was covering R16's it. R16 brought a special spilling half (1/2) of stated "I can't feed -At 8:28 a.m. NA-B "Hospice feeds you breakfast."  -At 8:37 a.m. R16 hof milk and red juic cup to mouth very schest was observed of oatmeal on the work of oatmeal	observation on 9/15/15, from the land was lying in bed with the head to 45 degrees. A white cloth is chest with oatmeal spilled on boonful of oatmeal to mouth the teaspoon on chest. R16 myself I spill everything." was overheard informing R16, if for lunch, you feed yourself and a covered cup with a spout the on tray. R16 was able to lift slowly. At the same time R16's downwith one third of R16's bowly white cloth that covered the ached R16 stated to surveyor, they say they are too busy."  Observation on 9/16/15, from 0 a.m. were as follows: was still seated in wheelchair in did table. R16 stated was st. of ast trays arrived in unit on setting in room, tray table in reakfast tray had not been				
	-At 8:29 a.m. R16 v please help me with will come back and after I pass the resi	took tray in to R16's room. vas heard ask NA-A, "can you n breakfast?" NA-A replied, "I help you if I have the time t of the trays and get someone n front of the table with the tray				

6899

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00065	B. WING		09/1	7/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE MA	RGARET S PARMLY F	RESIDENCE	D TOWNE R			
0/0.15	CHIMMADV CTA	TEMENT OF DEFICIENCIES	CITY, MN 5		DNI .	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 830	Continued From page 20		2 830			
	- At 8:40 a.m. when R16 stated, "It was sitting here for over it. I asked for help to back. It is so hard a when I do that." -At 8:55 a.m. regist tray from room. R10 cereal and had druid The Care Area Assindicated "is eating requesting help with R16's nutritional sta 7/17/15, indicated "	atus care plan revised on resident is requesting room				
	7/17/15, indicated "resident is requesting room trays and feeding assist most meals."  R16's Minimum Data Set (MDS) dated 7/20/15, indicated R16 was alert and oriented with symptoms of moderate depression. The MDS Indicated R16 required assistance from staff with eating meals.					
		aily living (ADLs) care plan cated, "The resident requires se of 1 staff to eat."				
	9/16/15, include but (difficulty swallowing	from Admission Record dated t not limited to dysphagia g) due to cerebrovascular uscle weakness, major and anxiety.				
	9/17/15, indicated F 156.1 and on 9/11/1	itals Summary printed on R16's weight on 5/3/15, was I5, was 150.4 pounds. R16 tely 5.7 pounds in four				

6899

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00065		B. WING		09/	17/2015
	PROVIDER OR SUPPLIER RGARET S PARMLY F	RESIDENCE	28210 OL	DRESS, CITY, S D TOWNE R CITY, MN 5			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830	On 9/16/15, at 9:32 family made arrang come in at noon to eating. [R16] asked will back, but I was On 9/16/15, at 11:0 asks for assistance sit there." [R16] chook with understandinave to do feed her assistance are in the with [R16], some date not so good becarranged for the howen may need to redining room if [R16] to be passed within On 9/17/15, at 11:20 (DON) stated, "My oresident asks for het remor and may need to it herself." She reextensive assistance replied, "No. I will be report on this." R16 services to maintain Policy for providing requested from facility por resident nutritional changes to reflect or changes to reflect to the services to maintain policy for providing requested from facility por resident nutritional changes to reflect or changes to reflect to the services to the service	a.m. NA-A si ements for the feed [R16]. [Fill for help toda too busy." 5 a.m. RN-B in they are to hooses to eat in ing, if eats in reelf. People and to eat a special with the feed help of the feed help. It is eat help some equires per context and cares she filling a vulner did not received assistance will the feed help. It is eat help some equires per context and cares she filling a vulner did not received assistance will the feed help. It is eat help some equires per context and cares she filling a vulner did not received assistance will the feed help. It is eat help some equires per context and cares she filling a vulner did not received assistance will the feed help. It is eat the feed help. It is eat the feed help of the feed help of the feed help. It is eat the feed help of the feed help of the feed help. It is eat the feed help of the feed help of the feed help of the feed help. It is eat the feed help of the feed help	ne hospice aide to R16] needs help ay and I told her I stated "If [R16] neels her or at least noom. [R16] is room, [R16] may who need not it is difficult and someday's b's] tremor. We feed her lunch. beating. Trays are not or of nursing anytime a nem. She has a on and off. etimes she can are plan at. "She should not eat based on providing her ne needs? DON erable adult we the care and onal status. With eating was ovided.  **PRRECTION: The ignee could ssment of nake any needed.	2 830			

Minnesota Department of Health

Minnesota Department of Health

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICAT	SUPPLIER/CLIA ION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00065		B. WING	<del></del>	09/1	7/2015
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
THE MAI	RGARET S PARMLY F	RESIDENCE		D TOWNE R CITY, MN 5			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 22		2 830			
	DON could in-service and about how to couplan of care. The E ensure compliance.	orrectly implem OON could then	ent a resident's				
	TIME PERIOD FOR (21) days.	R CORRECTIC	N: Twenty-one				
2 905	MN Rule 4658.0525	5 Subp. 4 Reha	ab - Positioning	2 905			10/15/15
	Subp. 4. Positionin positioned in good to of residents unable must be changed a including periods of been put to bed for has documented th hours during this tin the physician has o	body alignment to change thei t least every tw time after the the night, unlea at repositioning ne period is ur	t. The position r own position to hours, resident has see the physician gevery two nnecessary or				
	This MN Requirements by: Based on observation review, the facility for assistance with rep (R16) identified at rulcers that was revi	on, interview, a ailed to provide ositioning for 1 isk of developii	and document necessary of 1 resident ng pressure		Corrected		
	Findings include:						
	During continuous of 7:08 a.m. until 11:00 noted: -7:08 a.m. R16 up i combed7:35 a.m. R16 sittii -7:50 a.m. R16 sittii -8:28 a.m. nursing a	a.m. and the n wheelchair go ng in wheel cha ng waiting for b	following was etting her hair air. breakfast.				

6899

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00065	B. WING		09/1	7/2015
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		-,
THE MA	RGARET S PARMLY F	RESIDENCE	D TOWNE R CITY, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 23	2 905			
2 300	R16 room. NA-A did-8:55 a.m. registered tray. RN-B did not response a.m. R16 where bed9:09 a.m. R16 where bed9:15 a.m. RN-A tales:33 a.m. RN-A stitunchanged9:44 a.m. Beauticides shop9:54 a.m. R16 sitticlosed. There was a that was approximated did not shift buttockes10:13 a.m. R16 sitticlosed. There was a that was approximated did not shift buttockes10:53 a.m. Beauticides a.m.	d not reposition R16 ed nurse (RN)-B picked up eposition R16. eeled herself slowly toward her king with R16 in R16's room. Il in room. R16's position an took R16 to the beauty ng in wheelchair with her eyes a cushion in the wheelchair ately three inches thick. R16 is. ting under the drier. R16 had				

Minnesota Department of Health

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00065	B. WING		09/1	7/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
THE MA	RGARET S PARMLY F	RESIDENCE	D TOWNE R			
0/0.15	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	CITY, MN 5		ONI	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 905	Continued From page 24		2 905			
	9/16/15, include bur effects of cerebrova muscle weakness, anxiety.	rom Admission Record dated t not limited to other late ascular disease (stroke), major depression, fatigue and				
	R16's care plan for "decreased physical mobility with potential for falls and impaired skin r/t dx of DJD [degenerative joint disease], chronic pain m/b [manifested/by] inability to transfer, ambulate, wheel self, turn/reposition" printed on 9/16/15, indicated "Turn and reposition resident every 2 hours and PRN [as needed] using pillows."					
	Assignment sheet f Q(every) 2H (hour)	eled Nursing Assistant or R16 indicated, "Reposition using pillows" and "turn and frequently-AT LEAST Q2H."				
	On 9/16/15, at 10:23 a.m. beautician stated, "[R16] gets her hair done weekly at the same time every week. The aides do not check on the residents unless I call them and say there is a problem. I come and get the residents and bring them back."					
	not usually get out	6 a.m. RN-B stated, R16 did of bed. R16 was able to tell us R16 was to be repositioned				
	skin is red but bland blanchable pressur infection that we are and more absorber expectation for repo	5 a.m. RN-B stated, "[R16's] chable there are no non e areas. She has a fungal e treating with Nystatin cream at brief." RN-B stated "My ositioning is if there is a current y one hour, otherwise at least rs."				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

O0065

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

28210 OLD TOWNE ROAD

CHISAGO CITY, MN, 55012

THE MAR	HE MARGARET S PARMLY RESIDENCE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
2 905	Continued From page 25	2 905				
	On 9/17/15, at 11:23 a.m. the director of nursing (DON) stated, "The expectation is [R16] has to be offloaded. We just did this enormous education on repositioning and pressure ulcer prevention. We could have asked [R16] to offload and offered to help. [R16] would be at risk for pressure ulcers, that is why we have alternating air mattress and cushion in w/c but [R16] still needs to be off loaded." When asked if your staff are providing her with the assistance and cares she needs. DON replied, "No. I will be filing a vulnerable adult report on this."  Prevention Of Pressure Ulcers procedure revised February 2014 instructed staff: "General Preventive Measures  3. For a person in a chair:  a. Change position at least every hour; and b. Use foam, gel or air cushion as indicated to relieve pressure"					
	SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could train all staff on ensuring each resident receives turning and repositioning assistance according to their assessed need. The DON or designee could then perform observational audits to determine compliance.					
	TIME PERIOD FOR CORRECTION: Twenty One (21) days.					
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence	2 910		10/15/15		
	Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the					

Minnesota Department of Health

STATE FORM 5699 ZNE511 If continuation sheet 26 of 39

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00065	B. WING		09/1	7/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE MA	RGARET S PARMLY F	RESIDENCE	D TOWNE R			
			CITY, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 910	Continued From page 26		2 910			
	comprehensive res home must ensure A. a resident w without an indwellin unless the resident' that catheterization B. a resident wh receives appropriat prevent urinary trace	ident assessment, a nursing				
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure catheter tubing was managed in a manner to potentially minimize the pulling and tugging of the inserted catherter for 2 of 2 residents (R176, R159) reviewed for urinary incontinence.			Corrected		
	being wheeled into assistant (NA)-G. A the table to adjust FR176 was observed grimaced as if in pawas pulling on the W/C, lying on the W/C, lying on the tubing coiled and cawheel. The cathete bag under the W/C out and was dragge immediately, bent of W/C. NA-G was the	d on 9/16/15, at 8:38 a.m. the dining room by nursing is NA-G wheeled R176 around R176's wheelchair (W/C), it to grab on his crotch, facially ain, and indicated something catheter tubing. Underneath the floor, was the catheter aught under the left front in bag was stored inside a blue, however the tubing was left and on the floor. NA-G stopped over and looked under the en observed to lift the front to get the tubing off the front				

Minnesota Department of Health

STATE FORM 5699 ZNE511 If continuation sheet 27 of 39

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00065	B. WING		09/	17/2015
	PROVIDER OR SUPPLIER	RESIDENCE 28210 C	DDRESS, CITY, S LD TOWNE RO O CITY, MN 5	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 910	under the W/C. NAhis table then was of then went over to we noted in the cathete.  On 9/17/15, at 7:50 been brought to the R176 was observed from the nursing stafform the medication was observed lying and the tubing was wheel approximated time observed sevenever offered or adubing.  R176's diagnoses in hypertrophy prostat other lower symptotract infections and III obtained from the Communications should be served and monimal of the R176's urinary incontact catheter Care Area 9/1/15, indicated R176's indicated R	ne tubing into the blue bag -G continued to wheel R176 to observed speak briefly to R17 trash hands. No blood was er tubing.  a.m. even after concern had a attention of the unit manager diseated on the W/C across ation approximately four feet in cart and the catheter tubing on the floor under the W/C close to the left front W/C close to the left front W/C ly three centimeters. At the eral staff walk past R176 and dressed to adjust the catheter included difficulty walking, we with urinary obstruction and ms, personal history of urinary chronic kidney disease stage in MD/Nursing in the dated 8/20/15.  Intinence and indwelling Assessment (CAA) dated 176 was to be free of traumating catheter and staff was to tor. R176's care plan dated 176 had an indwelling catheter ostatic hyperplasia (BPH) with the retention. The care plan sition the catheter bag and well of the bladder and away in door and check the tubing for the staff was to the catheter bag and well of the bladder and away in door and check the tubing for the staff was to the catheter bag and well of the bladder and away in door and check the tubing for the staff was to the catheter bag and well of the bladder and away in door and check the tubing for the staff was to the catheter bag and well of the bladder and away in door and check the tubing for the staff was to the staff				
		order signed but undated, or a Foley catheter 16 French				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  (X3)			X3) DATE SURVEY COMPLETED	
		00065	B. WING		09/1	17/2015
	PROVIDER OR SUPPLIER	RESIDENCE 28210 O	DDRESS, CITY, S LD TOWNE R O CITY, MN		•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 910	with 5-10 cc balloor On 9/16/15, at 12:0 (RN)-E unit nurse n going to be educate catheter bag was not that way and the state the extra tubing was caught by the whee was going to check had not been injure on that morning.  On 9/16/15, at 11:4 to follow up on the of had assisted R176 transferred him into thought she had tue blue bag under the was something like the tubing to make stated "Sometimes what am saying."  R159 was observed seated on her whee area in front of the catheter bag was of bag under the W/C approximately two a observed lying on the tubing was noted to entire visible length -At 1:37 p.m. activit the unit as she state bring her to the dini birthday party. As A the catheter tubing	5 p.m. registered nurse nanager stated staff were ed about it. She indicated the ot supposed to be positioned aff was supposed to ensure in the bag to prevent being larger R176 to make sure the penision of as a result of being pulled.  O a.m. NA-G was interviewed observation she stated she to get ready that morning and the wheelchair and she oked the extra tubing into the W/C. When asked if there a clip that was used to secure sure it does not roll out she they don't hold well you know they don't hold well you know be they don't hold well you know be they don't covered and the or have yellow urine along the				

Minnesota Department of Health

STATE FORM 5899 ZNE511 If continuation sheet 29 of 39

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S	SUPPLIER/CLIA TION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				A. BUILDING.			
		00065		B. WING		09/1	7/2015
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE MAI	RGARET S PARMLY F	RESIDENCE		D TOWNE R CITY, MN 5			
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 910	Continued From paralong the length stiration the tubing room (Distubing still lying on the tubing still lying on the tubing still lying on the tubing visible. Whallway outside the R159 W/C and did  On 9/16/15, at 7:00 seated on the W/C common area. Whe she was doing R15 had slept "pretty go observed all dresselying again on the fit the entire approximate catheter bag was sunderneath the W/G just hanging along and the entire approximate. At 8:23 a.m. the he wheeled R159 off the still lying on the floor and the dining room of the DR to the being dragged on the At 9:13 a.m. R159 out of the DR to the being dragged on the Chapel catheter floor.  At 10:50 a.m. R15 W/C in the common station the catheter visible. When stands several staff went processed and NA's not on 9/17/15, at 7:50	III.  22 p.m. R159 w R) seated at the the floor with 2 While observing DR several stanot conceal the analysis of the floor with yellow at the floor with yellow at the length of the len	e table catheter and ½ feet of g R159 from the aff went past e tubing.  Is observed television in the land asked how loing well and e R159 was leter tubing was a urine noted on at and the le bag black clip was libing.  In her W/C at the still lying on the latheter tubing wheeled catheter tubing in the R159 into gging on the led seated on the from the nursing in the floor sing station C including store it properly.	2 910			
	been brought to the						

6899

Minnesota Department of Health

STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00065	B. WING		09/1	7/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE MA	RGARET S PARMLY F	RESIDENCE	D TOWNE R CITY, MN 5			
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 910	9/16/15, R159 was across from the nur approached the cat lying on the floor ur approached and as being exposed both respond but smiled finger through a sturn R159's diagnoses i behaviors, Alzheim weakness, unspecineurogenic bladder obtained from MD/I dated 9/9/15.  R159's Physician Corder for a Foley cacentimeter (cc) ball R159's care plan directed shad an indwelling coretention secondary care plan directed shad and tubing beloaway from entrance tubing for kinks with On 9/16/15, at 10:5 (NA)-F stated she had cares which included done a quick swipe would pinch during On 9/16/15, at 12:0 (RN)-E unit nurse mas lying on the floand the staff were generally and selections.	observed seated on her W/C rsing station, when theter tubing was observed ider the W/C. When ked if the catheter tubing hered her R159 did not and continued to run her affed dog she was holding.  Included dementia without er's disease, muscle fied retention of urine, and urinary obstruction Nursing Communication sheet order dated 9/9/15, revealed an atheter 16 French with 10 cubic idea to neurogenic bladder. The staff to position the catheter ow the level of the bladder and it room door and check the in cares each shift.  O a.m. nursing assistant has assisted R159 with all the ed catheter cares and had on the catheter as R159	2 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						SURVEY PLETED	
		00065		B. WING		09/1	17/2015
	PROVIDER OR SUPPLIER	RESIDENCE	28210 OL	DRESS, CITY, S D TOWNE R CITY, MN 5	··-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE: Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 910	supposed to ensure bag to prevent bein further stated if the clip was not able to from rolling out of breport to the nurse with tubing would b  On 9/17/15, at 9:06 (DON) stated the cathe floor and be unabag. DON further stated long" to prevent and also thought was Both R176 and R15 necessary care and tubing placment as bladder function.  SUGGESTED MET The director of nursinservice staff regarcatheter use.	e the extra tubing wang caught by the when staff had identified the secure the tubing to pag the NAs were supimmediately and a new terms of the secure the tubing to pag the NAs were supimmediately and a new terms of the secure tubing to the secure tubing	el. RN-E ne plastic prevent it posed to ew bag  nursing be off id in the uld not be ng caught ol issue. neter paired  TION: d of	2 910			
21015	Requirements- Sal Subp. 7. Sanitary procedures and cor	O Subp. 7 Dietary Stanitary conditions. Sanitary nditions must be maile dietary department.	ntained in	21015			10/15/15
	This MN Requirement by:	ent is not met as evi	denced				

6899

Minnesota Department of Health

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00065		B. WING		09/1	7/2015
	PROVIDER OR SUPPLIER	RESIDENCE	28210 OL	DRESS, CITY, S D TOWNE R O CITY, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21015	Continued From particles and a sanitation procedure possibility of food by potential to affect 8 which was served for Findings include:  During kitchen tour following sanitation confirmed by the direct (DNS):  - four burner stove substance on the frect (approximately 1" we the stove (1/2" width backsplash to the boof the cast iron stove a greasy black substance on the four burner stove greasy substance of sides of the door. Do cleaned and stated completed on the wear of the catch basin. DN and housekeeping machines.  - ice machine on Paracross from nursing the ice shoot and not the catch basin which	on, interview and illed to follow eques that would mi orne illness. This of 87 residents bod out of the kit on 9/14/15, at 1 concerns were orector of nutrition had a heavy built ont top aluminur width X 24" length a X 18" length) a lack of the stove re top grates had a buildup on and around the NS verified it ne major oven clear eekends.  The PAC (transition chenette was drippoted to have staged a kind of the staged arkside unit in the gratation was drippoted to have staged arkside unit in the gratation was drippoted to have staged arkside unit in the gratation was drippoted to have staged arkside unit in the gratation was drippoted to have staged arkside unit in the gratation was drippoted to have staged to have sta	uipment nimize the s had the s in the facility, tchen.  :00 p.m. the observed and n services  dup of a black n piece n), right side of and on the . The corners d a buildup of n door below of a brown e handle and eded to be aning is  nal care) unit oping out of gnant water in aintenance e for these ice  e hallway oping out of gnant water in		Corrected		
	During a follow-up k	kitchen tour on 9	/16/15, at				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00065	B. WING		09/1	7/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/1	172010
THE MA	RGARET S PARMLY F	RESIDENCE	D TOWNE R			
		CHISAGO	CITY, MN 5		211	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21015	Continued From pa	ge 33	21015			
	10:15 a.m. the follo observed and verifi	wing sanitation concerns were ed by the DNS:				
	brown substance of on the inside front of was closed the subholding bin of ice us brown substance w by the DNS.	e kitchen had a buildup of a n the right side of the door and of the machine. When the door stance was directly above the sed for resident use. This as easily removed and verified				
	preparation table had the left of the dispositive buildup of black/brosubstance on and a inch diameter pipe piping going to the connecting joint surdirty with heavy dus surfaces. Piping dir valve to the left of the top of the food poiled with dirt/food buildup was scrape stated she was not	that was part of the food ad extensive piping located to sal. There was a heavy own mix of dirt and food type around an approximate two that went into the flooring, all left and right of it and around faces. An electric outlet was st/dirt buildup next to the piping ectly connected to the water he garbage disposal closer to preparation table was heavily debris. When the debris d with a spatula, the DNS sure what the substance was do have been cleaned.				
	wrapped on a hook lower 24 inches of t piece of material wi duct tape. This lowe	ole drainage hose feet in length was hanging to the right of the unit. The the hose was taped to a hard th frayed, heavily soiled red er section was the area that ched to drain the hose after				
		re wall tiles were missing on of the wall located behind the				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00065	B. WING		09/1	7/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE MA	RGARET S PARMLY F	RESIDENCE	D TOWNE R			
(VA) ID	SHIMMA DV STA	TEMENT OF DEFICIENCIES	CITY, MN 5	PROVIDER'S PLAN OF CORRECTION	- NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21015	Continued From pa	ge 34	21015			
	During environmental tour on 9/17/15, at 9:50 a.m. with the director of maintenance (DM) the following was observed:					
	out of the ice shoot was plugged and it A resident wash bac collecting the drippi approximately 1/4 f	e PAC unit was still dripping, the drain in the catch basin was filled with stagnant water. sin was under the ice shoot ng water and was noted to be ull. DM stated the machine is d they have a system to clean				
	- Ice machine on the Parkside unit was now draining however water still was dripping down the ice shoot was.					
	DNS stated the kitch the cleaning schedulast month. However	on 9/17/15, at 7:43 a.m. the hen ice machine was not on alle but maintenance cleaned it er, the former maintenance ords clean thus there was no erify this.				
	thru September 12, bottom oven and over weekly verified by s machine was not lis	en cleaning schedules for May 2015 indicated the stove top, ven fronts were cleaned taff initials. The kitchen ice sted on the cleaning  No cleaning schedules from provided.				
	and Equipment date machine and equip on a regular basis t condition by removi	g Instructions: Ice Machine ed 2010, indicated the ice ment (scoops) will be cleaned o maintain a clean, sanitarying the ice and washing the of the machine thoroughly olution.				

Minnesota Department of Health

STATE FORM 5699 ZNE511 If continuation sheet 35 of 39

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	E SURVEY MPLETED		
		00065		B. WING		09/1	7/2015
					STATE, ZIP CODE		
THE MARGARET S PARMLY RESIDENCE 28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21015	Continued From page 35		21015				
	Ovens dated 2010, cleaned as needed schedule (at least of policy was provided surrounding area. SUGGESTED MET The dining director develop, review and procedures to ensure cleaned. The DD or appropriate staff on	R CORRECTION:	I be eaning No top and ON: I ste all s, and				
21665	A nursing home must functional, comfortate environment, allowing personal belongings.  This MN Requirements: Based on observation did not ensure adec provided for 1 of 1 renvironmental concensure the environment manner for 5 of 8 reservirons.	D Physical Environment of Physical Environment ast provide a safe, clear able, and homelike physical provides to the resident to use so to the extent possible and interview, the facuate sound levels were resident (R45) reviewed the resident (R45) reviewed the facility fair ment was maintained in esidents (R66, R198, R for environmental control of the residents (R66, R198, R for environmental control of the review of th	n, sical nced acility ed for led to a safe 104,	21665	Corrected		10/15/15
	Findings include:						

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00065	B. WING		09/1	7/2015
			DRESS, CITY, S	STATE, ZIP CODE	•	
THE MAI	RGARET S PARMLY F	RESIDENCE	D TOWNE R			
(V4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	CITY, MN 5	PROVIDER'S PLAN OF CORRECTION	)NI	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	COMPLETE DATE
21665	Continued From pa	ge 36	21665			
	R45 was asked if s temperature, lightin building that affecte the air conditioner of was noisy and cold talked to the facility reset her thermome always work.	7 p.m. during interview when he any problems with the g, noise or anything else in the ed your comfort, R45 stated over her recliner in her room. R45 further stated she had and thought they had tried to eter in the room but it did not imum Data Set (MDS) dated				
	9/1/15, indicated R45's cognition was intact and had minimal hearing difficulty.					
	tour with the director noise was observed cooling system which sat in her recliner. I loud, too noisy." The stated "it is fixable, if the facility perform indicated random a no documentation of every staff had the TELS system (an osystem) and staff s	a.m. during the environmental or of maintenance (DM), a loud d coming out of above head the was right over R45 as she During the tour R45 stated "it is e DM verified the issue and it is a flow valve." When asked ned routine audits DM udits were done but "there is on audits." DM further stated ability to put work orders in the nline campus wide work order hould report any issue and can y from immediate too low.				
	duct tape approxim secure a seam on t in the center of the room. On the same bedroom, approxim length of the vinyl fl missing creating a pareas created an unthey would need to	om had frayed, ragged gray ately five feet in length used to he vinyl flooring. The area was first bedroom as you enter the seam in the second ately 1/4 inch by one foot in ooring was broken off and cotential tripping hazard. Both incleanable surface. DM stated strip the vinyl, glue the seam. DM verified both areas need				

Minnesota Department of Health

STATE FORM 5699 ZNE511 If continuation sheet 37 of 39

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00065	B. WING		09/1	7/2015
THE MARGARET S PARMLY RESIDENCE 28210 OLI			DRESS, CITY, S D TOWNE R			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21665	to be repaired.  R66's quarterly Min 8/29/15, indicated R cognition and requi most activities of da R198's admission R198 had severely required extensive R104 and R106's reapproximately five seam on the vinyl for the room. DM stabecause they may R104's annual MDS R104 had severely extensive assistance care area assessm R106's quarterly M R106 had severely required extensive of daily living (ADL' R8's room had gray feet in length used flooring located at the R8's quarterly MDS had severely impair extensive assistance.  During an interview stated maintenance hourly for any issued	simum Data Set (MDS) dated R66 had severely impaired red extensive assistance with aily living (ADL's).  MDS dated 8/11/15, indicated impaired cognition and assistance with most ADL's.  Doom had gray duct tape, feet in length used to secure a coring located at the entrance ated "staff put tape on it have thought it was unsafe."  So dated 5/16/15, indicated impaired cognition, required the with most ADL's and had a ent trigger for falls.  DS dated 7/4/15, indicated impaired cognition and assistance with most activities solution.  A duct tape, approximately five to secure a seam in the vinyl he entrance of the room.  A dated 6/15/15, indicated R8 red cognition and required the with most ADL's.  To 09/17/15, at 10:46 a.m. DM as looked at the TELS system as DM stated "it is a very easy they go over it in new	21665			

PRINTED: 10/30/2015 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00065 09/17/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 28210 OLD TOWNE ROAD THE MARGARET S PARMLY RESIDENCE CHISAGO CITY, MN 55013 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21665 Continued From page 38 21665 Review of the undated Ecumen Parmly LifePointes Orientation Guide NA/R (registered nursing assistant) directed maintenance to teach how to fill out a maintenance request and provided some examples that might be a safety concern, such as plumbing problems, damaged walls, chipping paint or wall scrapes. Review of the facility Process for Requesting Maintenance Orders policy dated 10/31/14, directed staff to submit a TELS (an online campus wide work order system) request for any issues related to patient safety such as fall precautions and to identify the issue as Critical on the TELS request. The policy further directed staff to call the on-call maintenance staff member if the computers were not in working order. SUGGESTED METHOD OF CORRECTION: The director of facility operations could review and revise the policies, educate maintenance staff and identify trends of repeated building disrepair. The director of facility operations could work with the director of nursing (DON) to ensure staff are reporting environmental issues appropriately. Time Period for Correction: Twenty-one (21) days.

6899