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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ZNE5
Facility ID: 00065

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245328**
2.STATE VENDOR OR MEDICAID NO.
(L2) **427240400**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE MARGARET S PARMLY RESIDENCE**
(L4) **28210 OLD TOWNE ROAD**
(L5) **CHISAGO CITY, MN** (L6) **55013**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)
6. DATE OF SURVEY **11/18/2015** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **101** (L18)
13.Total Certified Beds **101** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	101			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Sass, HFE NEII 12/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/06/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/13/2015
(L33)

DETERMINATION APPROVAL

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

CCN: 5328

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 complalint 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, 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 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

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

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245328	A. Building B. Wing	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

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

(Y4) Item: ID Prefix	Reg. #	LSC	(Y5) Date Correction Completed
F0278	483.20(g) - (j)		10/15/2015
F0280	483.20(d)(3), 483.10(k)(2)		10/15/2015
F0282	483.20(k)(3)(ii)		10/15/2015
F0312	483.25(a)(3)		10/15/2015
F0314	483.25(c)		10/15/2015
F0315	483.25(d)		10/15/2015
F0371	483.35(i)		10/15/2015
F0456	483.70(c)(2)		10/16/2015
F0465	483.70(h)		10/15/2015
F0514	483.75(l)(1)		10/15/2015

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	GL/mm	11/25/2015	31223	11/18/2015
Reviewed By CMS RO				

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245328	01 - MAIN BUILDING 01	11/10/2015

Name of Facility	Street Address, City, State, Zip Code
THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0011	**10/15/2015**	ID Prefix Reg. # **NFPA 101** LSC K0017	**10/15/2015**	ID Prefix Reg. # **NFPA 101** LSC K0018	**10/15/2015**
ID Prefix Reg. # **NFPA 101** LSC K0029	**10/15/2015**	ID Prefix Reg. # **NFPA 101** LSC K0046	**10/15/2015**	ID Prefix Reg. # **NFPA 101** LSC K0050	**10/15/2015**
ID Prefix Reg. # **NFPA 101** LSC K0052	**10/15/2015**	ID Prefix Reg. # **NFPA 101** LSC K0054	**10/15/2015**	ID Prefix Reg. # **NFPA 101** LSC K0056	**10/15/2015**
ID Prefix Reg. # **NFPA 101** LSC K0062	**10/15/2015**	ID Prefix Reg. # **NFPA 101** LSC K0064	**10/15/2015**	ID Prefix Reg. # **NFPA 101** LSC K0067	**10/15/2015**
ID Prefix Reg. # **NFPA 101** LSC K0069	**10/15/2015**	ID Prefix Reg. # **NFPA 101** LSC K0076	**10/15/2015**	ID Prefix Reg. # **NFPA 101** LSC K0144	**10/15/2015**

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	TL/mm	11/25/2015	27200	11/10/2015
Reviewed By CMS RO				

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245328	A. Building 01 - MAIN BUILDING 01 B. Wing	11/10/2015

Name of Facility	Street Address, City, State, Zip Code
THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0147	10/15/2015	ID Prefix Reg. # NFPA 101 LSC K0154	10/15/2015	ID Prefix Reg. # NFPA 101 LSC K0155	10/15/2015

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	TL/mm	11/25/2015	27200	11/10/2015

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/21/2015			

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

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245328	A. Building B. Wing 02 - THE MARGARET S. PARMLEY RESIDENCE	11/10/2015

Name of Facility	Street Address, City, State, Zip Code
THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	10/15/2015	ID Prefix Reg. # NFPA 101 LSC K0046	10/15/2015	ID Prefix Reg. # NFPA 101 LSC K0050	10/15/2015
ID Prefix Reg. # NFPA 101 LSC K0052	10/15/2015	ID Prefix Reg. # NFPA 101 LSC K0054	10/15/2015	ID Prefix Reg. # NFPA 101 LSC K0056	10/15/2015
ID Prefix Reg. # NFPA 101 LSC K0062	10/15/2015	ID Prefix Reg. # NFPA 101 LSC K0064	10/15/2015	ID Prefix Reg. # NFPA 101 LSC K0067	10/15/2015
ID Prefix Reg. # NFPA 101 LSC K0075	10/15/2015	ID Prefix Reg. # NFPA 101 LSC K0144	10/15/2015	ID Prefix Reg. # NFPA 101 LSC K0154	10/15/2015
ID Prefix Reg. # NFPA 101 LSC K0155	10/15/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	TL/mm	11/25/2015	27200	11/10/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/21/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-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

AH Form Approved
11/25/2015

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00065	A. Building B. Wing	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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	**10/15/2015**	ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp. 4** LSC	**10/15/2015**	ID Prefix **20625** Reg. # **MN Rule 4658.0450 Subp. 1 A-I** LSC	**10/15/2015**
ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	**10/15/2015**	ID Prefix **20905** Reg. # **MN Rule 4658.0525 Subp. 4** LSC	**10/15/2015**	ID Prefix **20910** Reg. # **MN Rule 4658.0525 Subp. 5 A.I** LSC	**10/15/2015**
ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp. 7** LSC	**10/16/2015**	ID Prefix **21665** Reg. # **MN Rule 4658.1400** LSC	**10/16/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/ mm	11/25/2015	31223	11/18/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/17/2015			

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

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

ID: ZNE5
Facility ID: 00065

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245328**
2. STATE VENDOR OR MEDICAID NO. (L2) **427240400**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE MARGARET S PARMLY RESIDENCE**
(L4) **28210 OLD TOWNE ROAD**
(L5) **CHISAGO CITY, MN** (L6) **55013**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **09/17/2015** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **101** (L18)
13. Total Certified Beds **101** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	101			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Rebecca Wong, HFE NE II 10/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 11/12/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/01/1986** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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;**

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
susanne.reuss@state.mn.us
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING ______ B. WING ______	09/17/2015

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278		10/15/15

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

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F 278	Continued From page 1 resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was coded accurately for 1 of 3 residents (R88) reviewed for dental concerns. Findings include: On 9/14/15, at 4:34 p.m. when asked if she had any problems with her teeth, dentures or gums R88 stated "I don't have teeth but they don't hurt and I don't have pain." -At 4:42 p.m. during general observations R88 was noted to have multiple missing teeth in the entire mouth when R88 opened the mouth and on the front lower jaw root tips were noted to have dark discoloration. On 9/16/15, at 7:09 a.m. when approached and asked how she had slept R88 stated not good as she smiled. When asked about oral cares R88 stated staff had used some mouth wash. R88's care plan dated 5/5/14, indicated R88 had the potential for oral/dental health problems related to broken teeth on lower jaw and had only two full teeth on the lower jaw and R88 needed set up and reliance on staff for oral hygiene. R88's quarterly MDS dated 4/17/15, revealed	F 278	In relation to assessment accuracy/coordination/certified, it is the policy of the facility that assessments accurately reflect the status of each resident. In relation to R88, the care plan has been updated to accurately reflect the resident¿s current dental status of one tooth in the mandible. Additionally, the CP was updated to reflect the resident¿s preference for oral care needs. The annual MDS dated 7/16/15 was modified with CAA completed to accurately reflect the oral status of the resident. The facility will identify potentially affected residents by auditing all of the resident charts to ensure the dental status of each resident is accurately reflected in the plan of care, nursing assessment and MDS. Those noted to be incorrect will be updated and modifications to MDS will be completed. The measures put into place to ensure that the aforementioned deficient practice does not reoccur include; 1) the nursing staff will review and sign all oral health assessment forms to ensure accurate information is updated and reflected on	

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F 278	Continued From page 2 dental section was left blank of any dental concerns which included but not limited to broken or loosely fitting full or partial denture, no natural teeth or tooth fragments, abnormal mouth tissue, obvious cavity or loose natural teeth, inflamed or bleeding gums, mouth or facial pain, discomfort or difficulty with chewing. During further review of annual MDS dated 7/16/15, it was revealed "None of the above present" option had been checked. Review of documents revealed the following: -Apple Tree Dental MDS 3.0 Oral/Dental Assessment Form dated 6/10/15, indicated R88 had obvious or likely cavity or broken natural teeth, had root tips, missing teeth, required direct staff assistance with oral cares and had denied pain at the time of assessment. -Apple Tree Chart Progress Notes dated 8/27/15, revealed R88 had one intact tooth. In addition, the dental section Care Area Assessment (CAA) did not trigger for CAA completed on 7/25/15. R88 diagnoses included hemiplegia affected non-dominant side due cerebrovascular disease (CVD), muscle weakness generalized, difficulty walking and unspecified cataract obtained from MD (medical doctor)/Nursing Communications sheet dated 9/9/15. On 9/16/15, at 8:57 a.m. registered nurse (RN)-E stated R88 ate every early and was among the first once to be served about 7:45 a.m. -At 9:07 a.m. when approached and asked how was breakfast R88 stated "It was good" when asked if she had any discomfort or pain when eating food R88 stated "No."	F 278	the plan of care and the NAR sheets; 2) the nurses will ensure oral health screenings are accurately reflected with each nursing assessment and MDS completed going forward. Education has been provided to the nursing staff performing nursing assessments on the policy, ¿Resident Examination and Assessment¿ to ensure accurate assessment, documentation and MDS coding of resident oral health. All staff received education on October 6th and 7th on regulation and standards of practice. Observational audits in conjunction with chart audits will be conducted for each resident, then with the next two dental day visits and finally quarterly to ensure compliance with the regulation. The Quality Assurance Performance Improvement (QAPI) committee will determine if discontinuation of audits is indicated once practice has been deemed to be sustained and compliant. Responsible Person: Director of Nursing or Designee	

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On 9/16/15, at 10:55 a.m. nursing assistant (NA)-G stated she had assisted R88 with all her morning cares and for oral cares she had set her up to brush her teeth but R88 had declined and told her she only would rinse with mouth wash and she was able to swish twice. NA-G indicated R88 was able to verbalize her needs and cares. When asked if she knew if R88 had teeth in her mouth NA-G stated she would get back to surveyor about that.

On 9/16/15, at 1:03 p.m. NA-G approached surveyor stated she had checked and found R88 had only one tooth in her mouth on the lower jaw.

On 9/17/15, at 9:10 a.m. the director of nursing (DON) reviewed the annual MDS dated 7/16/15, and verified MDS had not been coded accurately. DON indicated a modification had been completed for the same MDS upon opening it she verified dental/oral section was the same and was not accurate. DON stated she would have expected the MDS to be accurate and reflective of current resident oral/dental status.

On 9/17/15, at 9:24 a.m. RN-D who also was an MDS coordinator verified and acknowledged the MDS was not accurate and indicate with the assessment which had been completed 6/10/15, the dental issues that had been identified should have been reflected in the MDS a month later. RN-D acknowledged if the information had been entered in the annual MDS the dental CAA would have triggered. RN-D further stated another MDS coordinator who was working on-call basis had completed the MDS at that time and was not at the facility during the survey time.

According to the Long Term Care Facility

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F 278	Continued From page 4 Resident Assessment Instrument User's Manual version 3.0 dated last revised on October 2014, dental status must be coded on the MDS when all of the following criteria are met: "Check L0200 A, broken or loosely fitting full or partial denture: if the denture or partial is chipped cracked, uncleanable, or loose. A denture is coded as loose if the resident complains that it is loose, the denture visibly moves when the resident opens his or her mouth, or the denture moves when the resident tries to talk. · Check L0200 B, no natural teeth or tooth fragment(s) (edentulous): if the resident is edentulous or lacks all natural teeth or parts of teeth. · Check L0200 C, abnormal mouth tissue (ulcers, masses, oral lesions): Select if any ulcer, mass, or oral lesion is noted on any oral surface. · Check L0200 D, obvious or likely cavity or broken natural teeth: if any cavity or broken tooth is seen. · Check L0200 E, inflamed or bleeding gums or loose natural teeth: if gums appear irritated, red, swollen, or bleeding. Teeth are coded as loose if they readily move when light pressure is applied with a fingertip."	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280		10/15/15

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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, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, facility failed to update the care plan after falls for 1 of 4 resident (R21) reviewed for accidents.

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.

On 9/16/15, at 2:00 p.m. nursing assistant (NA)-I was interviewed and when asked what she did to prevent R21 from falling NA-I stated "I talk to [R21] a lot, provide distractions, spend time with her. [R21] likes to stack things. Therapy is working with [R21]. Walking would benefit her. She does try to stand up on her own."

On 9/17/15, at 7:48 a.m. was interviewed and R21 stated, "I bruise easily, I must have fallen."

In relation to the Right to Participate Planning Care/Revise CP, it is the policy of the facility that reads, ¿Assessments of residents are ongoing and care plans are revised as information about the resident and the resident¿s condition change.¿

For R21, the care plan has been updated to reflect the current level of care needed for this resident. The care plan has been updated to reflect fall prevention interventions and a bowel and bladder program was implemented to promote urinary and bowel continence.

To ensure other residents are not affected by the deficient practice, incident/accidents will be reviewed at our daily IDT stand-up meeting. The interventions will be reviewed and care plans updated to ensure compliance.

To ensure compliance with this policy, an incident/accident log has been created

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R21's care plan dated 8/18/15, indicated R21 had potential for injury (falls) related to impaired physical mobility, cognitive impairment, medication use. The care plan interventions included adjust bed to appropriate height, gripper socks, assist of for all transfers/ ambulation, assistive devices as needed (PRN), fall precautions PRN, transfer belt with all transfers, call light within reach, remind every shift to call for help and not to be left unattended in bathroom.

R21's medical record was reviewed and the following noted R21 had fallen on 8/23/15, 8/29/15, and 9/6/15. Even though interventions had been developed following each of the falls of which two had significant injuries R21's care plan had not been updated to reflect the interventions. The falls were as follows:
-Confidential Peer Review Document Resident Incident Report dated 8/23/15, indicated, R21 was found sitting on floor of the dining room and had sustained a skin tear on the left index finger and a 12 centimeter (cm) long by 4 cm deep gash to the left forearm. The report indicated immediate interventions implemented to prevent further falls were, to continue bowel and bladder monitoring to establish patterns to develop a bowel and bladder program, R21 was given a different wheelchair and labs for baseline status were done. R21 did receive a new w/c and the labs had been completed. Even though R21 was care planned to be toileted every two hours, the facility did not develop and implement an individualized program for bowel and bladder after the fall.

-Confidential Peer Review Document Resident Incident Report dated 8/29/15, indicated, NA found R21 lying on the floor in the day room. No

Provider's plan of correction (F 280):

documenting updated care plans, NAR sheets and interventions. This log will be ongoing.

Responsible Person(s):Director of Nursing and Executive Director or Designee

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F 280	Continued From page 7	F 280		

injury indicated. The report indicated interventions implemented were, to continue physical therapy (PT) and occupational therapy (OT) to address wheelchair positioning and the nurse practitioner or doctor was to review blood pressure's due to elevation. The medical review noted the physician had checked the blood pressures. Although, R21 received PT/OT, the care plan was not revised to reflect the therapies.

-Confidential Peer Review Document Resident Incident Report dated 9/6/15, indicated, R21 was witnessed bending over reaching to the floor in Martha's dining room and fell to the floor hitting the head. R21 had sustained a 3 cm laceration and large bump to forehead with bruising. The report interventions implemented were for OT to assess R21 for a tilt in space wheelchair, assess for vision field cut and to continue to work with R21 on safety and PT was to continue to work with R21 on balance and strengthening. Although R21 received OT, the medical record was void of any information regarding the assessment of the field cut. The tilt and space w/c was not added to the plan of care.

R21's diagnoses included dementia, hypertension, other fracture, lumbago, peripheral retinal degeneration and difficulty walking obtained from the admission Minimum Data Set (MDS) dated 8/25/15. The MDS also indicated R21 was severely cognitively impaired and required assistance with activities of daily living (ADL). In addition the MDS indicated R21 had fallen since admission or the prior assessment and had a fracture related to a fall in the six months prior to admission.

On 9/17/15, at 8:18 a.m. registered nurse (RN)-C

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	245328	A. BUILDING ______ B. WING ______	09/17/2015

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 8 stated, falls are reviewed by the interdisciplinary team (IDT). RN-C indicated after a progress note had been done and the care plan was supposed to be updated. RN-C verified the care plan had not been updated with new fall interventions since admission and even though R21 had sustained two significant injuries since admission at the facility. Care Plans-Comprehensive policy revised October 2010 directed staff: "An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident ... " In addition the policy indicated: " 8. Assessments of residents are ongoing and care plans are revised as information about the resident's condition change...."	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, facility failed to provide assistance with eating and repositioning in accordance with care plan for 1 of 1 resident (R16) reviewed for hospice. Findings include:	F 282	In relation to Services by Qualified Person/Per Care Plan, it is the facility¿s policy that services are provided or arranged by qualified persons in accordance with a resident¿s plan of care. In relation to R16, a VA was filed with	10/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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F 282 Continued From page 9

Eating:
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. nursing assistant (NA)-B was overheard informing R16, "Hospice feeds you for lunch, you feed yourself breakfast."
-At 8:37 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 on the white cloth that covered the chest. When approached R16 stated to surveyor, "I ask for help and they say they are too busy."

During continuous observation on 9/16/15, from 7:20 a.m. until 11:00 a.m. were as follows:
-At 7:20 a.m. R16 was still seated in wheelchair in front of over the bed table. R16 stated was waiting for breakfast.
-At 7:58 a.m. Breakfast trays arrived in unit on cart.
-At 8:06 a.m. R16 sitting in room, tray table in front of resident. Breakfast tray had not been delivered.
-At 8:28 a.m. NA-A took tray in to R16's room.
-At 8:29 a.m. R16 was heard ask NA-A, "can you please help me with breakfast?" NA-A replied, "I will come back and help you if I have the time after I pass the rest of the trays and get someone else up." R16 sat in front of the table with the tray food.
-At 8:34 a.m. all room trays had been passed.
- At 8:40 a.m. when asked how was breakfast?

F 282

OHFC and an investigation was conducted. The staff members working with R16 were educated on Resident¿s Rights and the resident¿s need for assistance with feeding and repositioning. The resident¿s plan of care was reflective of R16¿s current needs. The system of passing trays on the station has been modified to ensure R16¿s tray is delivered per R16¿s preferred time and assisted by staff with eating. Additionally, R16¿s preference for where R16 eats in room has been determined and the plan of care has been updated to reflect this preference.

The facility will identify residents potentially affected by the deficient practice by auditing residents receiving room trays to ensure the plan of care is being followed along with noted preferences for dining. Furthermore, residents at risk for skin breakdown and on repositioning programs will be audited for compliance.

To ensure the deficient practice does not recur all staff were re-educated on October 6th and 7th related to CP compliance, resident choice, prevention of skin breakdown and passing of meal trays. The NAR sheets have been updated to reflect the date last updated. The NAR sheets will be signed by the NAR caring for each group and returned to the nurse manager after every shift. Observational and chart audits will be conducted daily x 2 weeks, weekly x4, then monthly to ensure trays are delivered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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) COMPLETION DATE
F 282	Continued From page 10 R16 stated, "It was good once I got it. I have been sitting here for over an hour before they brought it. I asked for help to eat, but she never came back. It is so hard and I spill on myself. I hate it when I do that." -At 8:55 a.m. registered nurse (RN)-B removed tray from room. R16 had eaten 100 percent of hot cereal and had drunk a quarter of cup of milk. R16's nutritional status care plan revised on 7/17/15, indicated "resident is requesting room trays and feeding assist most meals." R16's activities of daily living (ADLs) care plan revised 8/7/15, indicated, "The resident requires extensive assistance of 1 staff to eat." Diagnoses for R16 from Admission Record dated 9/16/15, include but not limited to dysphagia (difficulty swallowing) due to cerebrovascular disease (stroke), muscle weakness, major depression, fatigue and anxiety. Undated/unlabeled Nursing Assistant Assignment sheet for R16 indicated, "Assist of 1 for all ADLs." On 9/16/15, at 9:32 a.m. nursing assistant (NA)-A said, R16 needed help eating. "[R16] asked for help today and I told her I will back, but I was too busy." On 9/16/15, at 11:05 a.m. RN-B stated "If [R16] asks for assistance they are to help her or at least sit there." [R16] chooses to eat in room. [R16] is ok with understanding, if eats in room, [R16] may have to do feed herself. People who need assistance are in the dining room. It is difficult with [R16], some days are good and some days are not so good because of [R16's] tremor. We	F 282	timely, plan of care is followed and NAR sheets are signed and turned into the nurse manager. In addition, turning and repositioning audits will be completed daily x 2 weeks, then weekly x4, and then monthly. The Quality Assurance Performance Improvement (QAPI) will determine if discontinuation of audits is indicated once current practice has been deemed sustained and compliant Completion Date: October 15, 2015 Person(s) Responsible: Director of Nursing Executive Administrator	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013**

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F 282	Continued From page 11	F 282		

arranged for the hospice aide to feed her lunch. We may need to revisit with [R16] eating in the dining room if [R16] needs help eating. Trays are to be passed within 15 minutes.

On 9/17/15, at 11:23 a.m. director of nursing (DON) stated, "My expectation is anytime a resident asks for help you help them. She has a tremor and may need help. It is on and off. Sometimes she needs help sometimes she can do it herself." She requires per care plan extensive assistance of one to eat. "She should not have to ask for assistance to eat based on this." When asked if your staff providing her with the assistance and cares she needs. DON replied, "No. I will be filing a vulnerable adult report on this."
Policy for providing assistance with eating was requested from facility but not provided.
Repositioning:
During continuous observation on 9/16/15, from 7:08 a.m. until 11:00 a.m.
-7:08 a.m. R16 up in wheelchair getting her hair combed.
-7:35 a.m. R16 sitting in wheel chair.
-7:50 a.m. R16 sitting waiting for breakfast.
-8:28 a.m. NA-A took tray in to R16 room. NA-A did not reposition R16.
-8:55 a.m. registered nurse (RN)-B picked up tray. RN-B did not reposition R16.
-9:09 a.m. R16 wheeled herself slowly toward her bed.
-9:15 a.m. RN-A talking with R16 in R16's room.
-9:33 a.m. RN-A still in room. R16's position unchanged.
-9:44 a.m. the beautician took R16 to the beauty shop.
-9:54 a.m. R16 sitting in wheelchair with her eyes closed. There was a cushion in the wheelchair

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013**

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F 282	Continued From page 12	F 282		

that was approximately three inches thick. R16 did not shift buttocks.
-10:13 a.m. R16 sitting under the drier. R16 had not changed positions.
-10:53 a.m. the beautician brought R16 back to room.
-11:00 a.m. R16's bottom was observed with the assistance of NA-C, during transfer from wheel chair to toilet. Bottom was purple red from top of coccyx to peri area extending outward on buttock approximately five centimeters (cm) on either side of center. No Open areas were observed. The area did not appear to have a rash. The incontinent product was dry. The area blanched when NA pressed on area to clean skin. NA-C stated, "This is redder than she normally is."

Pressure ulcer care area assessment dated 4/27/15, indicated "Resident is at risk for skin break down r/t [related/to] friction/shear potential, varied oral intakes, advance age, and decreased mobility."

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

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F 282	Continued From page 13 [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. On 9/16/15, at 11:05 a.m. RN-B stated, [R16's] skin was red but blanchable there are no non blanchable pressure areas. She has a fungal infection that we are treating with Nystatin cream and more absorbent brief. RN-B stated "my expectation for repositioning is if there is a current pressure ulcer every one hour, otherwise at least offer every two hours." On 9/17/15, at 11:23 a.m. the DON stated, "the expectation was [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 are your staff providing her with the assistance and cares she needs. DON replied,"No. I will be filing a vulnerable adult report on this."	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		10/15/15

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THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

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F 312	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 breakfast." -At 8:37 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 on the white cloth that covered the chest. When approached R16 stated to surveyor, "I ask for help and they say they are too busy."	F 312	In relation to ADL Care Provided for Dependent Residents, it is the policy of the facility to provide necessary service to residents who are unable to carry out activities of daily living in an effort to maintain good nutrition, grooming and personal and oral hygiene. In relation to R16, a VA was filed with OHFC and an investigation was conducted. The staff members working with R16 were educated on Resident¿s Rights and the resident¿s need for assistance with feeding and repositioning. The resident¿s plan of care was reflective of R16¿s current needs. The system of passing trays on the station has been modified to ensure R16¿s tray is delivered per R16¿s preferred time and assisted by staff with eating. Additionally, R16¿s preference for where R16 eats in room has been determined and the plan of care has been updated to reflect this preference. The facility will identify residents potentially affected by the deficient practice by auditing residents receiving room trays to ensure the plan of care is	

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THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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F 312

Continued From page 15

During continuous observation on 9/16/15, from 7:20 a.m. until 11:00 a.m. were as follows:
-At 7:20 a.m. R16 was still seated in wheelchair in front of over the bed table. R16 stated was waiting for breakfast.
-At 7:58 a.m. Breakfast trays arrived in unit on cart.
-At 8:06 a.m. R16 sitting in room, tray table in front of resident. Breakfast tray had not been delivered.
-At 8:28 a.m. NA-A took tray in to R16's room.
-At 8:29 a.m. R16 was heard ask NA-A, "can you please help me with breakfast?" NA-A replied, "I will come back and help you if I have the time after I pass the rest of the trays and get someone else up." R16 sat in front of the table with the tray food.
-At 8:34 a.m. all room trays had been passed.
- At 8:40 a.m. when asked how was breakfast? R16 stated, "It was good once I got it. I have been sitting here for over an hour before they brought it. I asked for help to eat, but she never came back. It is so hard and I spill on myself. I hate it when I do that."
-At 8:55 a.m. registered nurse (RN)-B removed tray from room. R16 had eaten 100 percent of hot cereal and had drunk a quarter of cup of milk.

The Care Area Assessment (CAA) dated 4/22/15, indicated "...is eating most meals in her room and requesting help with feeding."

R16's nutritional status care plan revised on 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

F 312

being followed along with noted preferences for dining. Furthermore, residents at risk for skin breakdown and on repositioning programs will be audited for compliance.

To ensure the deficient practice does not recur all staff were re-educated on October 6th and 7th related to CP compliance, resident choice, prevention of skin breakdown and passing of meal trays. The NAR sheets have been updated to reflect the date last updated. The NAR sheets will be signed by the NAR caring for each group and returned to the nurse manager after every shift. Observational and chart audits will be conducted daily x 2 weeks, weekly x4, then monthly to ensure trays are delivered timely, plan of care is followed and NAR sheets are signed and turned into the nurse manager. In addition, turning and repositioning audits will be completed daily x 2 weeks, then weekly x4, and then monthly.

The Quality Assurance Performance Improvement (QAPI) will determine if discontinuation of audits is indicated once current practice has been deemed sustained and compliant.

Person(s) Responsible: Director of Nursing and Executive Administrator or Designee

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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) COMPLETION DATE
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symptoms of moderate depression. The MDS Indicated R16 required assistance from staff with eating meals.

R16's activities of daily living (ADLs) care plan revised 8/7/15, indicated, "The resident requires extensive assistance of 1 staff to eat."

Diagnoses for R16 from Admission Record dated 9/16/15, include but not limited to dysphagia (difficulty swallowing) due to cerebrovascular disease (stroke), muscle weakness, major depression, fatigue and anxiety.

The Weights and Vitals Summary printed on 9/17/15, indicated R16's weight on 5/3/15, was 156.1 and on 9/11/15, was 150.4 pounds. R16 had lost approximately 5.7 pounds in four months.

On 9/16/15, at 9:32 a.m. NA-A stated, ..."the family made arrangements for the hospice aide to come in at noon to feed [R16]. [R16] needs help eating. [R16] asked for help today and I told her I will back, but I was too busy."...
On 9/16/15, at 11:05 a.m. RN-B stated "If [R16] asks for assistance they are to help her or at least sit there." [R16] chooses to eat in room. [R16] is ok with understanding, if eats in room, [R16] may have to do feed herself. People who need assistance are in the dining room. It is difficult with [R16], some days are good and someday's are not so good because of [R16's] tremor. We arranged for the hospice aide to feed her lunch. We may need to revisit with [R16] eating in the dining room if [R16] needs help eating. Trays are to be passed within 15 minutes.

On 9/17/15, at 11:23 a.m. director of nursing

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THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013**

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F 312	Continued From page 17 (DON) stated, "My expectation is anytime a resident asks for help you help them. She has a tremor and may need help. It is on and off. Sometimes she needs help sometimes she can do it herself." She requires per care plan extensive assistance of one to eat. "She should not have to ask for assistance to eat based on this." When asked are your staff providing her with the assistance and cares she needs? DON replied,"No. I will be filing a vulnerable adult report on this." R16 did not receive the care and services to maintain good nutritional status. Policy for providing assistance with eating was requested from facility but not provided.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide necessary assistance with repositioning for 1 of 1 resident (R16) identified at risk of developing pressure ulcers that was reviewed for hospice. Findings include:	F 314	In relation to Treatment/Services to Prevent/Heal Pressure Sores, it is the policy of the facility to implement interventions to prevent the development of pressure sores and those with a pressure sore(s) receive necessary treatment and services to promote healing, prevent infection and prevent new	10/15/15

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THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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F 314	Continued From page 18 During continuous observation on 9/16/15, from 7:08 a.m. until 11:00 a.m. and the following was noted: -7:08 a.m. R16 up in wheelchair getting her hair combed. -7:35 a.m. R16 sitting in wheel chair. -7:50 a.m. R16 sitting waiting for breakfast. -8:28 a.m. nursing assistant (NA)-A took tray in to R16 room. NA-A did not reposition R16 -8:55 a.m. registered nurse (RN)-B picked up tray. RN-B did not reposition R16. -9:09 a.m. R16 wheeled herself slowly toward her bed. -9:15 a.m. RN-A talking with R16 in R16's room. -9:33 a.m. RN-A still in room. R16's position unchanged. -9:44 a.m. Beautician took R16 to the beauty shop. -9:54 a.m. R16 sitting in wheelchair with her eyes closed. There was a cushion in the wheelchair that was approximately three inches thick. R16 did not shift buttocks. -10:13 a.m. R16 sitting under the drier. R16 had not changed positions. -10:53 a.m. Beautician brought R16 back to room. -11:00 a.m. R16's bottom was observed with assistance of NA-C, during transfer from wheel chair to toilet. Bottom was purple red from top of coccyx to peri area extending outward on buttock approximately five centimeters (cm) on either side of center. No Open areas were observed. The area did not appear to have a rash. The incontinent product was dry. The area blanched when NA pressed on area to clean skin. NA-C stated, "This is redder than she normally is." Pressure ulcer care area assessment dated 4/27/15, indicated "Resident is at risk for skin	F 314	sores from developing. In relation to R16, a VA reported was filed with OHFC and investigation fully conducted. The staff members involved were educated to follow the plan of care to ensure the integrity of the resident¿s skin was maintained. Staff members educated to ensure residents unable to reposition or off-load independently are repositioned according to the plan of care to prevent breakdown of skin and maintain the integrity of the skin. R16 has a pressure alternating mattress on bed and pressure reducing cushion in wheelchair. Resident is also on a Q2H repositioning schedule. Resident does not have a pressure related injury to skin at this time. The NAR sheets have been updated to reflect the date last updated and NAR¿s are to sign and date after each shift and return to the Nurse Manager for the station. To ensure others are not affected by the deficient practice, all staff were re-educated on October 6th and 7th on prevention of pressure related injuries and to ensure the plan of care is followed. Additionally, staff will re-assess residents who are dependent on others for repositioning or off-loading and ensure risk factors have been assessed and interventions in place to prevent ulcerations or skin breakdown. Education was also provided on prevention of pressure ulcers and assessing risk factors. The nursing staff will continue to complete a thorough skin assessment with all new admits, quarterly and with	

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break down r/t [related/to] friction/shear potential, varied oral intakes, advance age, and decreased mobility."

R16's quarterly 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 all activities of daily living including mobility.

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."

The 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 needs help. R16 was to be repositioned

F 314

significant changes to determine risk factors and interventions.

Furthermore, the beauticians have been educated to ensure the staff are made aware and signed out when they have been assisted off the station to the beauty shop. The NAR¿s have been educated to assist the residents prior to leaving the station with repositioning/off-loading to prevent skin breakdown. Furthermore, residents at risk for skin breakdown and on repositioning programs will be audited for compliance.

To ensure the deficient practice does not recur, the NAR sheets have been updated to reflect the date last updated. The NAR sheets will be signed by the NAR caring for each group and returned to the nurse manager after every shift. Observational and chart audits will be conducted for turning and repositioning needs of residents daily x 2 weeks, weekly x4, then monthly to ensure the plan of care is followed and NAR sheets are signed and turned into the nurse manager.

The Quality Assurance Performance Improvement (QAPI) will determine if discontinuation of audits is indicated once current practice has been deemed sustained and compliant.

Person(s) Responsible: Director of Nursing and Executive Administrator or Designee

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F 314	Continued From page 20 every two hours. On 9/16/15, at 11:05 a.m. RN-B stated, "[R16's] skin is red but blanchable there are no non blanchable pressure areas. She has a fungal infection that we are treating with Nystatin cream and more absorbent brief." RN-B stated "My expectation for repositioning is if there is a current pressure ulcer every one hour, otherwise at least offer every two hours." 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...."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that	F 315		10/15/15

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F 315	Continued From page 21 catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This 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. Findings include: R176 was observed on 9/16/15, at 8:38 a.m. being wheeled into the dining room by nursing assistant (NA)-G. As NA-G wheeled R176 around the table to adjust R176's wheelchair (W/C), R176 was observed to grab on his crotch, facially grimaced as if in pain, and indicated something was pulling on the catheter tubing. Underneath the W/C, lying on the floor, was the catheter tubing coiled and caught under the left front wheel. The catheter bag was stored inside a blue bag under the W/C, however the tubing was left out and was dragged on the floor. NA-G stopped immediately, bent over and looked under the W/C. NA-G was then observed to lift the front portion of the W/C to get the tubing off the front wheel and tucked the tubing into the blue bag under the W/C. NA-G continued to wheel R176 to his table then was observed speak briefly to R176 then went over to wash hands. No blood was noted in the catheter tubing.	F 315	In relation to No Catheter, Prevent UTI, Restore Bladder, it is the policy of the facility to ensure catheter tubing is managed in a manner that minimizes pulling or tugging of the inserted catheter. For R176 and R159, the tubing has been adjusted and the clips are being utilized to ensure the tubing is off the floor. Site has ordered additional dignity bags to ensure the drainage bag and tubing fit properly into the bag. In addition, fabric dignity bags are being sewn by volunteers for use as needed to promote dignity. The facility will identify other residents with the potential to be affected by the deficient practice by auditing all current residents utilizing urinary catheters to ensure proper placement of drainage bags and tubing. Residents will be monitored qshift to ensure proper placement of urinary drainage bags and tubing to prevent potential injury to the resident. To ensure others are not affected, all residents admitted with or insertion of an indwelling catheter has been reviewed to ensure appropriate use. In addition, residents will be monitored every shift to ensure catheter tubing is free of kinks,	

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F 315	Continued From page 22 On 9/17/15, at 7:50 a.m. even after concern had been brought to the attention of the unit manager R176 was observed seated on the W/C across from the nursing station approximately four feet from the medication cart and the catheter tubing was observed lying on the floor under the W/C and the tubing was close to the left front W/C wheel approximately three centimeters. At the time observed several staff walk past R176 and never offered or addressed to adjust the catheter tubing. R176's diagnoses included difficulty walking, hypertrophy prostate with urinary obstruction and other lower symptoms, personal history of urinary tract infections and chronic kidney disease stage III obtained from the MD/Nursing Communications sheet dated 8/20/15. R176's urinary incontinence and indwelling catheter Care Area Assessment (CAA) dated 9/1/15, indicated R176 was to be free of trauma related to indwelling catheter and staff was to observed and monitor. R176's care plan dated 8/2/15, identified R176 had an indwelling catheter related to benign prostatic hyperplasia (BPH) with obstruction and urine retention. The care plan directed staff to position the catheter bag and tubing below the level of the bladder and away from entrance room door and check the tubing for kinks with cares each shift. R176's Physician Order signed but undated, revealed an order for a Foley catheter 16 French with 5-10 cc balloon. On 9/16/15, at 12:05 p.m. registered nurse (RN)-E unit nurse manager stated staff were going to be educated about it. She indicated the	F 315	storage of the urinary drainage tubing is below the bladder and properly secured and stored to prevent injury to the resident. To monitor compliance, nursing will conduct observational audits for residents utilizing indwelling urinary catheters daily x 2 weeks, then weekly x4 weeks, and finally monthly. The Quality Assurance Performance Improvement (QAPI) will determine if discontinuation of audits is indicated once current practice has been deemed to be sustained and compliant. Person(s) Responsible: Director of Nursing and Executive Administrator or Designee	

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catheter bag was not supposed to be positioned that way and the staff was supposed to ensure the extra tubing was in the bag to prevent being caught by the wheel. RN-E acknowledged she was going to check R176 to make sure the penis had not been injured as a result of being pulled on that morning.

On 9/16/15, at 11:40 a.m. NA-G was interviewed to follow up on the observation she stated she had assisted R176 to get ready that morning and transferred him into the wheelchair and she thought she had tucked the extra tubing into the blue bag under the W/C. When asked if there was something like a clip that was used to secure the tubing to make sure it does not roll out she stated "Sometimes they don't hold well you know what am saying."

R159 was observed on 9/15/15, at 1:28 p.m. seated on her wheelchair (W/C) in the common area in front of the television (TV) and the urinary catheter bag was observed stored inside a blue bag under the W/C but the extra tubing approximately two and a half (2 ½) feet was observed lying on the floor not covered and the tubing was noted to have yellow urine along the entire visible length.
-At 1:37 p.m. activity staff (A)-A wheeled R159 off the unit as she stated to R159 she was going to bring her to the dining room for the monthly birthday party. As A-A wheeled R159 off the unit the catheter tubing was noted dragging on the floor exposed and yellow urine was observed along the length still.
-At 1:40 p.m. to 2:52 p.m. R159 was observed in the dining room (DR) seated at the table catheter tubing still lying on the floor with 2 and ½ feet of

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the tubing visible. While observing R159 from the hallway outside the DR several staff went past R159 W/C and did not conceal the tubing.

On 9/16/15, at 7:00 a.m. R159 was observed seated on the W/C in front of the television in the common area. When approached and asked how she was doing R159 stated was doing well and had slept "pretty good." At the time R159 was observed all dressed and the catheter tubing was lying again on the floor with yellow urine noted on the entire approximately (2 ½) feet and the catheter bag was stored in the blue bag underneath the W/C and a plastic black clip was just hanging along the length of tubing.
-At 8:23 a.m. the health unit coordinator (HIC) wheeled R159 off the unit with the catheter tubing still lying on the floor dragging along.
-At 8:33 a.m. R159 was seated on her W/C at the DR table with the catheter tubing still lying on the floor in the dining room.
-At 9:13 a.m. R159 was observed being wheeled out of the DR to the unit with the catheter tubing being dragged on the floor.
-At 9:16 a.m. A-A was observed wheel R159 into the chapel catheter tubing still dragging on the floor.
- At 10:50 a.m. R159 was observed seated on the W/C in the common area across from the nursing station the catheter tubing lying on the floor visible. When standing at the nursing station several staff went past R159's W/C including nurses and NA's none offered to store it properly.

On 9/17/15, at 7:50 a.m. even after concern had been brought to the unit managers attention on 9/16/15, R159 was observed seated on her W/C across from the nursing station, when approached the catheter tubing was observed

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F 315	Continued From page 25 lying on the floor under the W/C. When approached and asked if the catheter tubing being exposed bothered her R159 did not respond but smiled and continued to run her finger through a stuffed dog she was holding. R159's diagnoses included dementia without behaviors, Alzheimer's disease, muscle weakness, unspecified retention of urine, neurogenic bladder and urinary obstruction obtained from MD/Nursing Communication sheet dated 9/9/15. R159's Physician Order dated 9/9/15, revealed an order for a Foley catheter 16 French with 10 cubic centimeter (cc) balloon. R159's care plan dated 8/31/15, identified R159 had an indwelling catheter related to urinary retention secondary to neurogenic bladder. The care plan directed staff to position the catheter bag and tubing below the level of the bladder and away from entrance room door and check the tubing for kinks with cares each shift. On 9/16/15, at 10:50 a.m. nursing assistant (NA)-F stated she has assisted R159 with all the cares which included catheter cares and had done a quick swipe on the catheter as R159 would pinch during cares. On 9/16/15, at 12:05 p.m. registered nurse (RN)-E unit nurse manager verified the catheter was lying on the floor stated it was a dignity issue and the staff were going to be educated about it. She indicated the catheter bag was not supposed to be positioned that way and the staff was supposed to ensure the extra tubing was in the bag to prevent being caught by the wheel. RN-E	F 315		

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F 315	Continued From page 26 further stated if the staff had identified the plastic clip was not able to secure the tubing to prevent it from rolling out of bag the NAs were supposed to report to the nurse immediately and a new bag with tubing would be changed. On 9/17/15, at 9:06 a.m. the director of nursing (DON) stated the catheter tubing should be off the floor and be under the chair hang and in the bag. DON further stated "the tubing should not be that long" to prevent the tubing from being caught and also thought was an infection control issue. Both DON and administrator acknowledged it was a dignity issue as not everyone needed to know a resident had a catheter. Both R176 and R159 did not receive the necessary care and services for the catheter tubing placment as to avoid potential impaired bladder function.	F 315		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow equipment sanitation procedures that would minimize the possibility of food borne illness. This had the	F 371	All areas identified have been thoroughly cleaned. Education and training was provided to all kitchen staff. The policy and procedure for cleaning schedules was	10/15/15

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F 371	Continued From page 27 potential to affect 85 of 87 residents in the facility, which was served food out of the kitchen. Findings include: During kitchen tour on 9/14/15, at 1:00 p.m. the following sanitation concerns were observed and confirmed by the director of nutrition services (DNS): - four burner stove had a heavy buildup of a black substance on the front top aluminum piece (approximately 1" width X 24" length), right side of the stove (1/2" width X 18" length) and on the backsplash to the back of the stove. The corners of the cast iron stove top grates had a buildup of a greasy black substance. The oven door below the four burner stove had a buildup of a brown greasy substance on and around the handle and sides of the door. DNS verified it needed to be cleaned and stated major oven cleaning is completed on the weekends. During a follow-up kitchen tour on 9/16/15, at 10:15 a.m. the following sanitation concerns were observed and verified by the DNS: - Garbage disposal that was part of the food preparation table had extensive piping located to the left of the disposal. There was a heavy buildup of black/brown mix of dirt and food type substance on and around an approximate two inch diameter pipe that went into the flooring, all piping going to the left and right of it and around connecting joint surfaces. An electric outlet was dirty with heavy dust/dirt buildup next to the piping surfaces. Piping directly connected to the water valve to the left of the garbage disposal closer to the top of the food preparation table was heavily	F 371	reviewed and updated. Audits will be completed daily x 2 weeks, weekly x4, then monthly to ensure compliance. The Quality Assurance Performance Improvement (QAPI) will determine if discontinuation of audits is indicated once current practice has been deemed sustained and compliant Person(s) Responsible: Director of Dining Services or Designee	

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F 371	Continued From page 28 soiled with dirt/food debris. When the debris buildup was scraped with a spatula, the DNS stated she was not sure what the substance was and verified it should have been cleaned. 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. The facility Cleaning Instructions: Ranges and Ovens dated 2010, indicated the ovens will be cleaned as needed and according to the cleaning schedule (at least once every two weeks). No policy was provided for cleaning the stove top and surrounding area.	F 371		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain equipment in a safe operating condition for 1 of 1 resident (R45) reviewed for environmental concerns and those residents who received ice from the ice machines out of the kitchen/kitchnettes. This had the potential to affect 85 of 87 residents in the	F 456	The air conditioning valve in R45's room was repaired. All staff has been educated to report any maintenance concern using the TELs system. Education is provided at each nursing station and throughout the building on how to submit a TELs request. To monitor compliance, nursing will	10/16/15

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facility.

Findings include:

On 9/14/15, at 12:27 p.m. during interview when R45 was asked if she any problems with the temperature, lighting, noise or anything else in the building that affected your comfort, R45 stated the air conditioner over her recliner in her room was noisy and cold. R45 further stated she had talked to the facility and thought they had tried to reset her thermometer in the room but it did not always work.

R45's quarterly Minimum Data Set (MDS) dated 9/1/15, indicated R45's cognition was intact and had minimal hearing difficulty.

On 9/17/15, at 9:30 a.m. during the environmental tour with the director of maintenance (DM), a loud noise was observed coming out of above head cooling system which was right over R45 as she sat in her recliner. During the tour R45 stated "it is loud, too noisy." The DM verified the issue and stated "it is fixable, it is a flow valve." When asked if the facility performed routine audits DM indicated random audits were done but "there is no documentation on audits." DM further stated every staff had the ability to put work orders in the TELS system (an online campus wide work order system) and staff should report any issue and can even choose priority from immediate too low.

During kitchen tour on 9/14/15, at 1:00 p.m. the following mechnical concerns were observed and confirmed by the director of nutrition services (DNS):

- ice machine on the PAC (transitional care) unit

F 456 (Plan of Correction)

conduct observational/auditory audits in resident areas daily x 2 weeks, then weekly x4 weeks, and finally monthly. The Quality Assurance Performance Improvement (QAPI) will determine if discontinuation of audits is indicated once current practice has been deemed to be sustained and compliant.

The ice machines on both the TCU and Park Unit are scheduled to be repaired 10/16/2015. To monitor compliance, Housekeeping will conduct audits daily x 2 weeks, then weekly x4 weeks, and finally monthly on all ice machines in resident areas. The Quality Assurance Performance Improvement (QAPI) will determine if discontinuation of audits is indicated once current practice has been deemed to be sustained and compliant.

All areas identified in the kitchen have been thoroughly cleaned. The duct tape has been removed from the hose and replaced with a washable clip. Education and training was provided to all kitchen staff. Audits will be completed daily x 2 weeks, weekly x4, then monthly to ensure compliance. The Quality Assurance Performance Improvement (QAPI) will determine if discontinuation of audits is indicated once current practice has been deemed sustained and compliant.

Person(s) Responsible: Director of Nursing and Director of Dining Service or Designee

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THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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across from the kitchenette was noted to have water dripping out of the ice shoot and noted to have stagnant water in the catch basin. DNS stated that maintenance and housekeeping were responsible for these ice machines.

- ice machine on Parkside unit in the hallway across from nursing station was dripping water out of the ice shoot and noted to have stagnant water in the catch basin which was not draining.

During a follow-up kitchen tour on 9/16/15, at 10:15 a.m. the following sanitation concerns were observed and verified by the DNS:

- Ice machine in the kitchen had a buildup of a brown substance on the right side of the door and on the inside front of the machine. When the door was closed the substance was directly above the holding bin of ice used for resident use. This brown substance was easily removed and verified by the DNS.

- Kitchen steam table drainage hose approximately four feet in length was hanging wrapped on a hook to the right of the unit. The lower 24 inches of the hose was taped to a hard piece of material with frayed, heavily soiled red duct tape. This lower section was the area that dietary workers touched to drain the hose after each meal use.

During environmental tour on 9/17/15, at 9:50 a.m. with the director of maintenance (DM) the following was observed:

- Ice machine on the PAC unit was still dripping water out of the ice shoot, the drain in the catch basin was plugged and it was filled with stagnant

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F 456	Continued From page 31	F 456		

water. A resident wash basin was under the ice shoot collecting the dripping water and was noted to be approximately 1/4 full. DM stated the machine was plugged up daily and they have a system to clean it out weekly.

- Ice machine on the Parkside unit was now draining however water still was dripping down the ice shoot.

During an interview on 9/17/15, at 7:43 a.m. the DNS stated the kitchen ice machine was not on the cleaning schedule but maintenance cleaned it last month. However, the former maintenance staff wiped the records clean thus there was no documentation to verify this.

Review of the kitchen cleaning schedules for May thru September 12, 2015 indicated the kitchen ice machine was not listed on the cleaning assignment sheets. No cleaning schedules from maintenance were provided.

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

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F 456	Continued From page 32 the computers were not in working order.	F 456		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the environment was maintained in a safe manner for 5 of 8 residents (R66, R198, R104, R106, R8) reviewed for environmental concerns. Findings include: On 9/17/15, at 9:30 a.m. during the environmental tour with the director of maintenance (DM), the following was noted: R66 and R198's room had frayed, ragged gray duct tape approximately five feet in length used to secure a seam on the vinyl flooring. The area was in the center of the first bedroom as you enter the room. On the same seam in the second bedroom, approximately 1/4 inch by one foot in length of the vinyl flooring was broken off and missing creating a potential tripping hazard. Both areas created an uncleanable surface. DM stated they would need to strip the vinyl, glue the seam and rewax the floor. DM verified both areas need to be repaired. R66's quarterly Minimum Data Set (MDS) dated	F 465	The flooring in R66, R8 and R198's room has been replaced. All staff has been educated to report any maintenance concern using the TELs system. Education is provided at each nursing station and throughout the building on how to submit a TELs request. To monitor compliance, housekeeping will conduct audits to ensure flooring is intact and safe for resident use daily x 2 weeks, then weekly x4 weeks, and finally monthly. The Quality Assurance Performance Improvement (QAPI) will determine if discontinuation of audits is indicated once current practice has been deemed to be 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 been educated to report any maintenance concern using the TELs system. Education is provided throughout the building on how to submit a TELs request.	10/15/15

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F 465	Continued From page 33	F 465		

8/29/15, indicated R66 had severely impaired cognition and required extensive assistance with most activities of daily living (ADL's).

R198's admission MDS dated 8/11/15, indicated R198 had severely impaired cognition and required extensive assistance with most ADL's.

R104 and R106's room had gray duct tape, approximately five feet in length used to secure a seam on the vinyl flooring located at the entrance of the room. DM stated "staff put tape on it because they may have thought it was unsafe."

R104's annual MDS dated 5/16/15, indicated R104 had severely impaired cognition, required extensive assistance with most ADL's and had a care area assessment trigger for falls.

R106's quarterly MDS dated 7/4/15, indicated R106 had severely impaired cognition and required extensive assistance with most activities of daily living (ADL's).

R8's room had gray duct tape, approximately five feet in length used to secure a seam in the vinyl flooring located at the entrance of the room.

R8's quarterly MDS dated 6/15/15, indicated R8 had severely impaired cognition and required extensive assistance with most ADL's.

During a follow-up kitchen tour on 9/16/15, at 10:15 a.m. the following sanitation concerns were observed and verified by the DNS:
- Two 4" X 4" square wall tiles were missing on the outside portion of the wall located behind the convection oven.

To monitor compliance, housekeeping will conduct audits to ensure ceiling tiles that are needing replacement are reported in TELs daily x 2 weeks, then weekly x4 weeks, and finally monthly. The Quality Assurance Performance Improvement (QAPI) will determine if discontinuation of audits is indicated once current practice has been deemed to be sustained and compliant.

Person(s) Responsible: Director of Housekeeping or Designee

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F 465	Continued From page 34 During an interview on 9/17/15, at 10:46 a.m. DM stated maintenance looked at the TELS system hourly for any issues. DM stated "it is a very easy system to use and they go over it in new employee training." 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.	F 465		
F 514 SS=F	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;	F 514		10/15/15

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F 514	Continued From page 35 and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain accurate medical records were complete for 5 of 5 residents (R32, R81, R41, R127, R197) and 2 of 2 discharged residents (R99, R70) reviewed for monthly pharmacist reviews. 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,	F 514	In relation to Resident Records Complete/Accurate/Accessible, it is the policy of the facility to maintain clinical records on each resident in accordance with accepted professional standards and practices; accurately documented; readily accessible; and systematically organized. In relation to residents R32, R81, R41, R127, R197, R99 and R 70, the individual medication regimen reviews have been obtained by the pharmacy and placed into each resident¿s medical record. Each resident¿s medication regimen was reviewed by the consulting pharmacist as required. The medication irregularities had been addressed by the MD/NP and placed in the resident¿s chart. The consulting pharmacist would then send a cumulative summary report for the residents reviewed at that time. If there were no irregularities, they were noted on the Patient Summary Report. This system has changed as each resident has a ¿Patient Summary Report¿ vs. an inclusive list for all the residents reviewed by the Pharmacist. To improve the Medication Regimen Review process and ensure each resident has an individualized Patient Summary Report, the pharmacist will provide the facility with an individualized Patient Summary Report with the pertinent	

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F 514	Continued From page 36 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 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. 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. R127's diagnoses included Alzheimer disease, epilepsy, anxiety, insomnia, delusional disorder, and explosive personality disorder obtained from Admission Record dated 9/17/15.	F 514	regulatory information. This report will be scanned into the resident¿s medical record. This process will ensure timely, organized, and easily accessible monthly medication reviews. To ensure compliance with the new process, audits will be conducted to ensure all current residents have a Consultant Pharmacist¿s Medication Review Summary Report in the electronic medical record. Chart audits will be conducted for all residents reviewed by the Pharmacist for the next two months. Then, chart audits will be conducted quarterly. The Quality Assurance Performance Improvement (QAPI) will determine if discontinuation of audits is indicated once current practice has been deemed to be sustained and compliant. Person(s) Responsible: Director of Nursing and Consulting Pharmacist or Designee	

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F 514	Continued From page 37	F 514		

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, February 2015, March 2015, April 2015, May 2015 and June 2015, July 2015, August 2015. 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 four noted irregularities and/or recommendations for R127. There were no consultant pharmacist's Medication Regimen Review recorded by the pharmacist in R127's chart.

R197's diagnoses included Alzheimer disease, dementia with behavioral disturbances, polymyalgia rheumatica, and neuropathy, obtained from Admission Record dated 9/17/15. R197 was admitted 8/4/15. There was no consultant pharmacist's Medication Regimen Review available in the medical record for October 2014, December 2014, January 2015, February 2015, March 2015, April 2015, May 2015 and June 2015, July 2015, August 2015. Review of the Consultant Pharmacist's Parmly Lifepointes Summary Reports kept in a binder in the director of nursing office dated 8/2015, showed four irregularities for the doctor to address during medication reconciliation.
On 9/17/15, at 9:00 a.m. the DON received the multi-patient monthly medication reviews, they cannot be placed in the individual patient medical records because they contain other patients names. The blank and undated Thrifty White

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Pharmacy Services Monthly Medication Regimen Reviews form was in the Consultant Pharmacist File (white 3 ring binder), but was not being used at the facility.

DISCHARGED RESIDENTS

R99's diagnoses included chronic pancreatitis, chronic airway obstruction, osteoporosis and malignant neoplasm upper lobe bronchus obtained from Admission Record dated 9/17/15.

R99 was admitted to the facility 5/23/15, and remained in the facility until 7/5/15. Review of Parmly Lifepointes Summary Reports, indicated the last consultant pharmacist review in the medical record was dated 6/2/15. There was no consultant pharmacist's Medication Regimen Review recorded by the pharmacist for June 2015 in R99's chart.

R70's diagnoses included anxiety, bipolar I disorder, insomnia, osteoporosis, hypertension, and cerebrovascular disease obtained from physician order record dated 5/15/15.

R70 was admitted to the facility 4/24/15 and remained in the facility until 6/8/15. Review of Parmly Lifepointes Summary Reports, indicated the last consultant pharmacist review in the medical record was dated 6/2/15. There was no consultant pharmacist's Medication Regimen Review recorded by the pharmacist for either May 2015, or June 2015 in R70's chart.

On 9/17/15, at 3:44 p.m. the consultant was called no answer.

On 9/17/15, at 11:00 a.m. the HIM director verified that monthly medication reviews should

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be in the individual charts, and used to be in the charts, but have not been since the new pharmacist took over.

On 9/17/15, at 3:44 p.m. a voicemail was left for the consultant Pharmacist (CP). On 9/18/15, at 1:30 p.m. the CP returned the call and stated the summary is collated onto a computer form, electronically and emailed or handed to the director of nursing, and that this process had been vetted by his director. The CP verified that the monthly medication review was not in each individual residents chart, since it was a collated summary.

The monthly medication review information was produced and maintained on a pharmacy based system and was not available within each individual residents medical record. The DON was provided a copy of each visit by the consultant pharmacist. The form contained the information of multiple patients monthly chart reviews, the consultant pharmacist visited the facility twice a month to complete all of the monthly reviews. To review an individual patients monthly medication review for the prior 12 months would involve looking at two printouts per month to find the residents medication changes (24 documents, and then the summary of recommendations, additional pages which number varied by month).

The Medication Regimen Review (Monthly Report) Policy indicated.... The CP perform a comprehensive medication regimen review (MMR) at least monthly. The MMR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and

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F 514	Continued From page 40 prevents or minimizes adverse consequences related to medication therapy. Findings and recommendations are reported to the director of nursing and the attending physician, and if appropriate the medication director and/or administrator... The facility lacked the necessary monthly medication reviews available in the individual resident chart, and in the closed medical records.	F 514		

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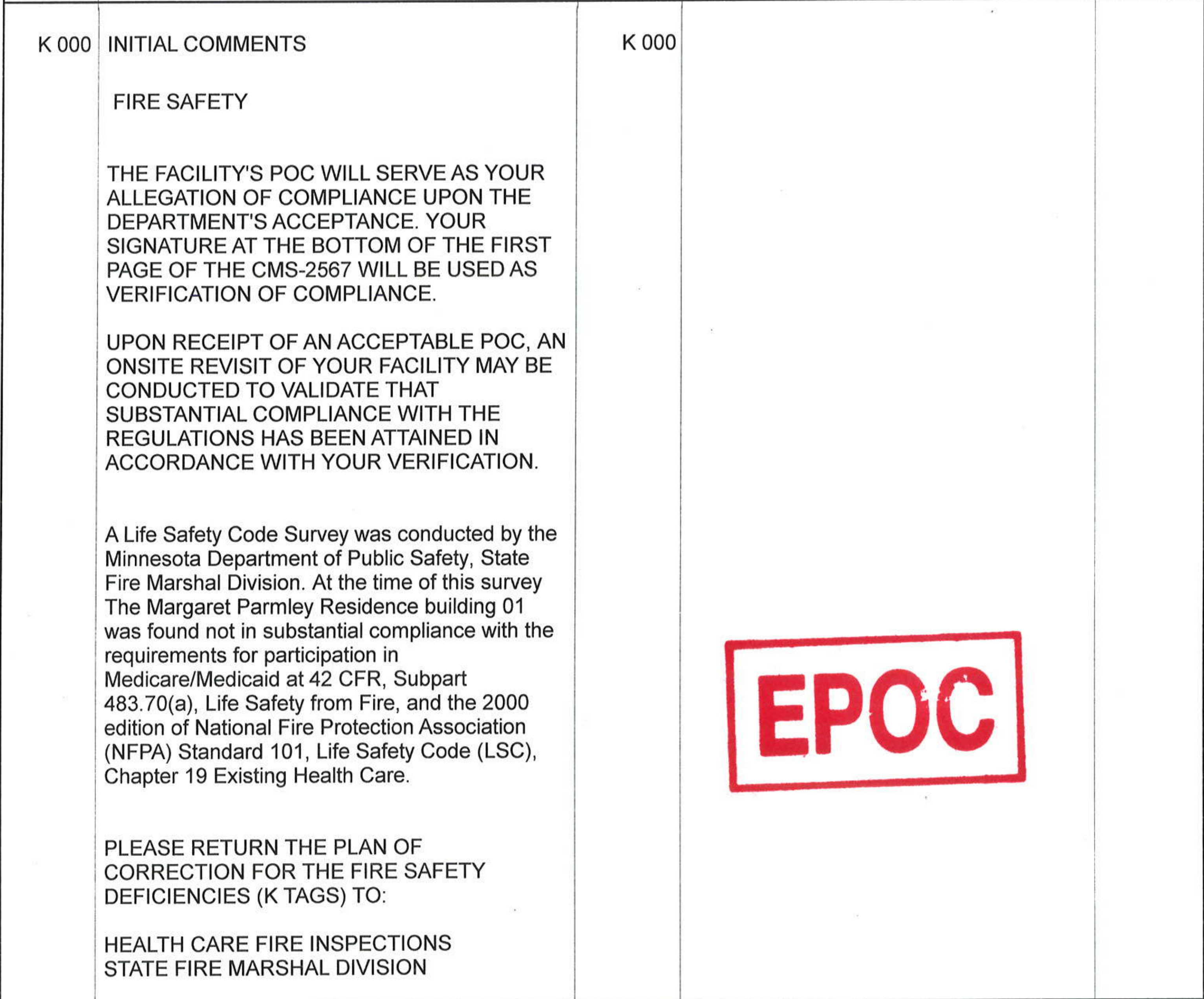

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT 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: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION	K 000	EPOC	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/21/2015**

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Margaret Parmley Residence is a 1-story building with a no basement. The building was constructed in 1972, construction Type II(111) with an addition, in 1999, construction Type II(111). Two assisted living buildings are connected and properly fire separated. Therefore, the facility was inspected as two different buildings. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 101 beds and had a census of 93 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 2 of 3 fire separations that were found not in compliance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.1 and 19.1.1.4.2,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect the residents, staff and visitors of the facility. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, observations revealed that the following deficient conditions were found affecting the facility's 2 hour fire separations: 1. there was a penetration found above the doors in the 2 hour fire wall that separates the chapel from the care center,	K 011	The penetration above the fire doors that separates the chapel from the care center has been sealed with 3M Fire Barrier . Sealant. A checklist has been created so that any future construction and/or electrical projects will be inspected by the Engineering Director to ensure fire wall barriers are intact. Fire doors located between the chapel and care center were repaired on 10/13/2015. A full audit of 100% the care center fire doors was completed to ensure all fire doors close properly. Fire doors will be inspected during each fire drill to ensure proper function. The 2x4 opening in the ceiling tile near Isabelle¿s House has been repaired. A checklist has been created so that any future construction and/or electrical	10/15/15

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K 011	Continued From page 3 2. the doors located in the 2 hour fire wall that is separating the chapel from the care center did not fully close and latch into the rated frame, and 3. there is a 2 by 4 opening above the ceiling tile located in the 2 hour fire wall separating the Isabella unit of the care center from the assisted living facility. This deficient condition was verified by the Maintenance Director (MC).	K 011	projects will be inspected by the Engineering Director to ensure fire wall barriers are intact. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility had penetrations located	K 017	The hole identified in the wall passing through the oxygen room into the adjunct	10/15/15

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K 017	Continued From page 4 in the corridor walls located in the facility that are not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting residents, staff and visitors. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, observations revealed, that there is a 1 inch diameter hole passing through the wall of the oxygen adjunct supply storage room into the corridor. This deficient condition was verified by the Maintenance Director (MC).	K 017	storage room into the corridor has been repaired. All staff has been educated to report any maintenance concern using the TELs system. Education is provided at each nursing station and throughout the building on how to submit a TELs request. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		10/15/15

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K 018	Continued From page 5	K 018		
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility had 1 of several corridor doors that did not meet the requirements of NFPA 101 LSC (00) section 19.3.6.3.2. This deficient practice could affect the safety of all residents, staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, observations revealed that the following deficient conditions were found affecting the corridor smoke barrier separations: 1. The door to resident room 119 did not fully shut and latch in the door frame, and 2. there are 2 Dutch style door that had door leaves that did not automatically latch together to ensure that both door leaves will close together in the event of an emergency. This deficient condition was verified by the Maintenance Director (MC).		The door latch to room 119 has been repaired and is working properly. The facility will monitor and sustain correction by completing audits on 10% of resident doors monthly. The results of audits will be reviewed in QAA and determination will be made for continued audits. The Dutch Style Doors have been secured together as one and an automatic closer has been installed on the door to ensure both door leaves close together in the event of an emergency. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029		10/15/15

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K 029	Continued From page 6 fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, observation revealed, that the following deficient conditions hazardous storage rooms throughout the facility: 1. There is a 6 inch by 8 inch penetration in the ceiling located in the Park Unit mechanical room, 2. the door to the Park Unit mechanical room	K 029	The 6x8" penetration identified ceiling of the Park Unit Mechanical Room has been repaired. A checklist has been created so that any future construction and/or electrical projects will be inspected by the Engineering Director to ensure fire wall barriers are intact. A door closer has been added to the Park Unit Mechanical Room. The Maintenance Director has identified each door with a closer on it. The facility will monitor and sustain correction by completing an audit of 10% of all doors with closers on them monthly. The results of audits will be reviewed in QAA and determination will be made for continued audits. Proper closers have been installed on both the Chapel Storage Room Door and the Chapel Mechanical Room Door. The Maintenance Director has identified each door with a closer on it. The facility will	

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K 029	Continued From page 7 was not equipped with a door closer, 3. the Chapel storage room door did not positively close and latch into the frame, and 4. the Chapel mechanical room door did not positively close and latch into the frame. This deficient condition was verified by the Maintenance Director (MC).	K 029	monitor and sustain correction by completing an audit of 10% of all doors with closers on them monthly. The results of audits will be reviewed in QAA and determination will be made for continued audits. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9.3, and 19.2.9.1. This deficient practice could residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Director (MC) revealed the that the facility failed to conduct the required Monthly 30 second and annual 90 minute testing of the battery backup emergency lights.	K 046	All EXIT lights were tested to ensure proper function. Education was provided for all maintenance staff on how to check for proper functioning of lights and regulatory guidelines. The facility will monitor and sustain correction by placing all monthly 30 second and annual 90 minute testing in the electronic preventative maintenance program (TELs), where they will be tracked and stored. Director of Maintenance and/or designee will be responsible for ongoing compliance.	10/15/15

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K 046	Continued From page 8 This deficient condition was verified by the Maintenance Director (MC).	K 046		
K 050 SS=F	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 drill documentation: 1. a evening shift drill in the first calendar quarter,	K 050	Maintenance Director completed a thorough search of records and gained access to old TELs reports. Completed Fire Drill records were found for all of the quarters in question. The facility will monitor and sustain compliance by placing all planned quarterly fire drills in the electronic preventative maintenance program (TELs), where they will be tracked and stored. Director of Maintenance and/or designee will be responsible for ongoing compliance.	10/15/15

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K 050	Continued From page 9 2. a overnight shift drill in the first calendar quarter, 3. a day shift drill in the second calendar quarter, 4. a evening shift drill in the third calendar quarter, 5. a overnight shift drill in the third calendar quarter, 6. a overnight shift drill in the fourth calendar quarter, This deficient condition was verified by the Maintenance Director (MC).	K 050		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and	K 052	Maintenance Director completed a thorough search of records and was able	10/15/15

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K 052	Continued From page 10 maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting all residents, staff, and visitors of the facility. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, observations and documentation review of all available fire alarm documentation for the last 12 months, and an interview with the Maintenance Director (MC), it was revealed that at the time of the inspection that the facility could not provide any current testing documentation for their fire alarm system. This deficient condition was verified by the Maintenance Director (MC).	K 052	to locate the annual testing documentation of the fire alarm system that was completed on February 10, 2015. The facility will monitor and sustain compliance by placing all planned annual fire alarm testing in the electronic preventative maintenance program (TELs), where it will be tracked and stored. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the	K 054	Maintenance Director completed a thorough search of records and was able to locate the sensitivity testing of each	10/15/15

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K 054	Continued From page 11 smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3.2.1. This deficient practice could affect all residents, visitors, and staff. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, a review of the facility's available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Director (MC) revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient condition was verified by the Maintenance Director (MC).	K 054	smoke detector located throughout the facility that was completed on February 5, 2014. The facility will monitor and sustain compliance by placing all required annual testing of the sensitivity of the smoke detectors in the electronic preventative maintenance program (TELs), where they will be tracked and stored. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056		10/15/15

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THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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K 056	Continued From page 12 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, observations revealed that there are 2 missing escutcheon ring located near resident room 115. This deficient condition was verified by the Maintenance Director (MC).	K 056	Missing escutcheon rings were replaced on 10/15/2015. The facility will monitor and sustain correction by completing an audit of 10% of all sprinkler heads monthly. The results of audits will be reviewed in QAA and determination will be made for continued audits. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect	K 062	Maintenance Director completed a thorough search of records and was able	10/15/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/21/2015**

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 13 and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect residents, staff and visitors. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, a review of documentation and interview with the Maintenance Director (MC) revealed that at the time of the inspection the facility failed to provide any documentation for a current annual fire sprinkler test having been completed. This deficient condition was verified by the Maintenance Director (MC).	K 062	to locate the annual fire sprinkler test that was completed on February 10, 2015. The facility will monitor and sustain compliance by placing all planned annual fire sprinkler testing in the electronic preventative maintenance program (TELs), where it will be tracked and stored. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility failed to maintain portable fire extinguishers in	K 064	Monthly fire extinguisher inspections will be completed timely. The facility will monitor and sustain compliance by	10/15/15

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	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/21/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

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K 064	Continued From page 14 accordance with NFPA 101-2000 edition, Section 9.7.4.1 and NFPA 10. This deficient practice could affect all residents, staff and visitors. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, the review of the fire extinguisher monthly inspection documentation for the past 12 months and observation revealed, that the facility failed to conduct 3 monthly inspections of the fire extinguishers that are located throughout the facility. This deficient condition was verified by the Maintenance Director (MC).	K 064	scheduling all fire extinguisher inspections in the electronic preventative maintenance program (TELs), where it will be tracked and stored. Monthly audits will be completed on 5 extinguishers per month. The results of audits will be reviewed in QAA and determination will be made for continued audits. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could allow smoke migration to negatively affect the safety of all residents, staff and visitors in the	K 067	Maintenance Director completed a thorough search of records and was able 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 in the electronic preventative maintenance	10/15/15

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	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/21/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

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K 067	Continued From page 15 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).	K 067	program (TELs), where it will be tracked and stored. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility has failed to ensure that 1 of 2 semi-annual inspections of the kitchen hood ventilation and fire suppression system protecting the cooking appliances have been completed. NFPA 96 8-3.1 per table 8-3.1, states that for moderate-volume cooking operations, the hood system and components shall be inspected and maintained semiannually by a properly trained, qualified, and certified company or person. This deficient practice could affect residents, all kitchen staff and visitors.	K 069	Maintenance Director completed a thorough search of records and was able to locate the semi annual Kitchen Hood Ventilation and Fire Suppression System Inspections Report dated 1/30/15. Another inspection was scheduled and completed on 10/5/2015. The facility will monitor and sustain compliance by placing all scheduled Kitchen Hood Ventilation and Fire Suppression System Inspections in the electronic preventative maintenance program (TELs), where it will be tracked and stored.	10/15/15

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	245328	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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K 069	Continued From page 16 Findings Include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, during the review of all available documentation for the kitchen hood ventilation and fire suppression system inspection reports, and interview with the Maintenance Director (MC), the facility failed to provide 2 of 2 service reports showing that the kitchen hood ventilation and fire suppression system has been professionally inspected within the last 12 month time period. This deficient condition was verified by the Maintenance Director (MC).	K 069	Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Observations revealed that the oxygen storage room was not maintained in accordance with	K 076	Fan motor for ventilation unit was replaced. The facility will monitor and	10/15/15

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	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/21/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 076	Continued From page 17 NFPA 99 Standards for Health Care Facilities (1999 edition) section 4-3.1.1.2. This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively residents, staff, and visitors in the event of an emergency. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, it was observed that the number of gaseous and liquid oxygen cylinders that are located in the oxygen storage room that is located in the oxygen storage room when calculated had an aggregate amount of compressed gases that is greater than 3000 cubic feet. It was also observed that the room that these cylinders are being stored in was not vented to the outside by a dedicated mechanical ventilation system or natural venting means that is in accordance with oxygen storage rooms that have more than 3000 cubic feet of compressed gases. This deficient condition was verified by the Maintenance Director (MC).	K 076	sustain correction by completing weekly audits to ensure proper function of the ventilation fan. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		10/15/15

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	245328	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 144	Continued From page 18 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all residents, staff, and visitors in the event of an emergency. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, documentation review of the emergency generator testing logs indicated that the facility could not locate or provide documentation for any of the weekly or monthly testing of the emergency power generator. This deficient condition was verified by the Maintenance Director (MC).	K 144	Weekly and monthly generator testing is currently being completed and logged. Maintenance staff were educated on how to complete the tests. The Policy and Procedure for generator testing was reviewed and is current. The facility will monitor and sustain compliance by completing monthly audits of generator test log. The results of audits will be reviewed in QAA and determination will be made for continued audits. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility was not limiting storage near electrical devices in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of residents, staff and visitors of the facility.	K 147	Storage room has been cleaned and organized. Par levels for items were adjusted as to not have as many combustible items in the storage closet. Wheelchairs were removed and organized for easy access to electrical panels. Floors and walls were clearly marked with	10/15/15

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	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**09/21/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

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K 147	Continued From page 19 Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, observations revealed that there was an excessive amount of combustible items being stored around and up against the electrical transformers and panels that are located in the wheel chair storage room. This deficient condition was verified by the Maintenance Director (MC).	K 147	red tape for staff to visualize where they cannot store items. Staff education was provided. The facility will monitor and sustain compliance by completing monthly audits of the storage rooms. The results of audits will be reviewed in QAA and determination will be made for continued audits. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff.	K 154	Maintenance Director completed a thorough search of records and was able to locate the Automatic Fire Sprinkler System Out of Service Policy. The policy was reviewed and is accurate. Director of Maintenance and/or designee will be responsible for ongoing compliance.	10/15/15

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	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**09/21/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

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K 154	Continued From page 20 Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, during record review and an interview with the facility manager, it was found that the facility could not provide a complete automatic fire sprinkler system out of service policy. This deficient condition was verified by the Maintenance Director (MC).	K 154		
K 155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff.	K 155	Maintenance Director completed a thorough search of records and was able to locate the Automatic Fire Alarm System Out of Service Policy. The policy was reviewed and is accurate. Director of Maintenance and/or designee will be responsible for ongoing compliance.	10/15/15

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	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/21/2015**

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THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

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K 155	Continued From page 21 Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, during record review and an interview with the facility manager, it was found that the facility could not provide a complete automatic fire alarm system out of service policy. This deficient condition was verified by the Maintenance Director (MC).	K 155		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **02 - THE MARGARET S. PARMLEY RESIDENCE** B. WING ______	**09/21/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-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), 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	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **02 - THE MARGARET S. PARMLEY RESIDENCE** B. WING	**09/21/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency This facility will be surveyed as two separate buildings. The 2007 addition is a 2-story building with no basement and was determined to be of Type II(111) construction. The upper floor has 12 resident rooms, and the lower level has a pool and therapy functions. It is properly separated from the original building and an assisted living facility on both levels. The building is fully sprinkler protected. The facility has a fire alarm system, with full corridor smoke detection and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that are interconnect with each other and is transmit to the nurses station.	K 000		

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	245328	A. BUILDING **02 - THE MARGARET S. PARMLEY RESIDENCE** B. WING ______	**09/21/2015**

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K 000	Continued From page 2 The facility has a licensed capacity of 101 beds and had a census of 93 at the time of the survey. . The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (00) section 18.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, observation revealed, that the following deficient conditions hazardous storage rooms throughout the facility:	K 029	The 1" hole and opening around the pipes in the humidifier room have been repaired. A checklist has been created so that any future construction and/or electrical projects will be inspected by the Engineering Director to ensure fire wall 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 continued audits. The Woodworking door closer was	10/15/15

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	245328	A. BUILDING **02 - THE MARGARET S. PARMLEY RESIDENCE** B. WING ______	**09/21/2015**

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 PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 3 1. There is a 1 inch hole and an opening around pipes in the humidifier room that is located in the TCU Unit, 2. the door to the TCU Unit soiled utility room did not positively close and latch into the frame, and 3. the Wellness storage room was converted into a wood working shop and does not have a self-closing door leading into the corridor. This deficient condition was verified by the Maintenance Director (MC).	K 029	repaired. The facility will monitor and sustain correction by completing an audit of 10% of all doors with closers on them monthly. The results of audits will be reviewed in QAA and determination will be made for continued audits. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1 This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested in accordance with NFPA LSC (00) Section 7.9.3, and 18.2.9.1. This deficient practice could residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Director (MC) revealed the that	K 046	All EXIT lights were tested to ensure proper function. Education was provided for all maintenance staff on how to check for proper functioning of lights and regulatory guidelines. The facility will monitor and sustain correction by placing all monthly 30 second and annual 90 minute testing in the electronic preventative maintenance program (TELs), where they will be tracked and stored. Director of Maintenance and/or designee will be responsible for ongoing compliance	10/15/15

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K 046	Continued From page 4 the facility failed to conduct the required Monthly 30 second and annual 90 minute testing of the battery backup emergency lights. This deficient condition was verified by the Maintenance Director (MC).	K 046		
K 050 SS=F	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. 18.7.1.2 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), 18.7.1.2, 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, staff and visitors of the facility. 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	K 050	Maintenance Director completed a thorough search of records and gained access to old TELs reports. Completed Fire Drill records were found for all of the quarters in question. The facility will monitor and sustain compliance by placing all planned quarterly fire drills in the electronic preventative maintenance program (TELs), where they will be tracked and stored. Director of Maintenance and/or designee will be responsible for ongoing compliance.	10/15/15

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

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K 050	Continued From page 5 that the facility failed to provide the following fire drill documentation: 1. a evening shift drill in the first calendar quarter, 2. a overnight shift drill in the first calendar quarter, 3. a day shift drill in the second calendar quarter, 4. a evening shift drill in the third calendar quarter, 5. a overnight shift drill in the third calendar quarter, 6. a overnight shift drill in the fourth calendar quarter, This deficient condition was verified by the Maintenance Director (MC).	K 050		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and	K 052	Maintenance Director completed a thorough search of records and was able	10/15/15

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K 052	Continued From page 6 maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting all residents, staff, and visitors of the facility. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, observations and documentation review of all available fire alarm documentation for the last 12 months, and an interview with the Maintenance Director (MC), it was revealed that at the time of the inspection that the facility could not provide any current testing documentation for their fire alarm system. This deficient condition was verified by the Maintenance Director (MC).	K 052	to locate the annual testing documentation of the fire alarm system that was completed on February 10, 2015. The facility will monitor and sustain compliance by placing all planned annual fire alarm testing in the electronic preventative maintenance program (TELs), where it will be tracked and stored. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted that required sensitivity testing of the	K 054	Maintenance Director completed a thorough search of records and was able to locate the sensitivity testing of each	10/15/15

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K 054	Continued From page 7 smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3.2.1. This deficient practice could affect all residents, visitors, and staff of the facility. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, a review of the facility's available fire alarm maintenance and testing documentation for the last 12 months, and an interview with the Maintenance Director (MC) revealed that at the time of the inspection the facility could not provide any current documentation verifying the completion of the required sensitivity testing of each smoke detector located throughout the facility. This deficient condition was verified by the Maintenance Director (MC).	K 054	smoke detector located throughout the facility that was completed on February 5, 2014. The facility will monitor and sustain compliance by placing all required annual testing of the sensitivity of the smoke detectors in the electronic preventative maintenance program (TELs), where they will be tracked and stored. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.	K 056		10/15/15

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K 056	Continued From page 8 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect the residents, visitors and staff of the facility. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, observations revealed that the storage that is located in the TCU linen room was within 18 inches of the sprinkler deflector. This deficient condition was verified by the Maintenance Director (MC).	K 056	The TCU Linen Room has been cleaned and organized. Par levels for items were adjusted. Walls were clearly marked with red tape for staff to visualize where they cannot store items. Staff education was provided. The facility will monitor and sustain compliance by completing monthly audits of the storage rooms. The results of audits will be reviewed in QAA and determination will be made for continued audits. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062		10/15/15

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K 062	Continued From page 9 Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 18.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect residents, staff and visitors. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, a review of documentation and interview with the Maintenance Director (MC) revealed that at the time of the inspection the facility failed to provide any documentation for a current annual fire sprinkler test having been completed. This deficient condition was verified by the Maintenance Director (MC).	K 062	Maintenance Director completed a thorough search of records and was able to locate the annual fire sprinkler test that was completed on February 10, 2015. The facility will monitor and sustain compliance by placing all planned annual fire sprinkler testing in the electronic preventative maintenance program (TELs), where it will be tracked and stored. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 064 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6 This STANDARD is not met as evidenced by: Based on documentation review and staff	K 064	Monthly fire extinguisher inspections will	10/15/15

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K 064	Continued From page 10 interview, it was determined that the facility failed to maintain portable fire extinguishers in accordance with NFPA 101-2000 edition, Section 9.7.4.1 and NFPA 10. This deficient practice could affect all residents, staff and visitors of the facility. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, the review of the fire extinguisher monthly inspection documentation for the past 12 months and observation revealed, that the facility failed to conduct 3 monthly inspections of the fire extinguishers that are located throughout the facility. This deficient condition was verified by the Maintenance Director (MC).	K 064	be completed timely. The facility will monitor and sustain compliance by scheduling all fire extinguisher inspections in the electronic preventative maintenance program (TELs), where it will be tracked and stored. Monthly audits will be completed on 5 extinguishers per month. The results of audits will be reviewed in QAA and determination will be made for continued audits. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the fire/smoke damper system has not been maintained in accordance with the requirements of NFPA 90(99) section 3-4.7. This deficient practice does not ensure the proper operation of the fire/smoke dampers and could	K 067	Maintenance Director completed a thorough search of records and was able to locate the annual damper testing document that was completed on February 10, 2015. The facility will monitor and sustain compliance by	10/15/15

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K 067	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).	K 067	placing all scheduled damper tests in the electronic preventative maintenance program (TELs), where it will be tracked and stored. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 075 SS=D	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 attended. 18.7.5.5	K 075		10/15/15

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K 075	Continued From page 12 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to store large trash and linen carts in properly protected rooms in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.7.5.5. This deficient practice could affect the safety of all residents, staff and visitors if smoke or fire from one of these carts rendered the corridors untenable. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, it was found that in the TCU Unit by the soiled utility room the facility was storing multiple mobile solid linen and trash container that are greater than 32 gallons in aggregate in spaces that are greater than 64 square feet (in area) and that are open to the corridors and not in the required hazardous storage areas. This deficient condition was verified by the Maintenance Director (MC).	K 075	Staff were educated on October 6 and 7, 2015 on proper use and storage of soiled linen and trash receptacles. To monitor compliance, environmental services will conduct observational audits for soiled linen and trash daily x 2 weeks, then weekly x4 weeks, and finally monthly. The Quality Assurance Performance Improvement (QAPI) will determine if discontinuation of audits is indicated once current practice has been deemed to be sustained and compliant. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by:	K 144		10/15/15

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K 144	Continued From page 13 Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all residents, staff, and visitors of the facility. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, documentation review of the emergency generator testing logs indicated that the facility could not locate or provide documentation for any of the weekly or monthly testing of the emergency power generator. This deficient condition was verified by the Maintenance Director (MC).	K 144	Weekly and monthly generator testing is currently being completed and logged. Maintenance staff were educated on how to complete the tests. The Policy and Procedure for generator testing was reviewed and is current. The facility will monitor and sustain compliance by completing monthly audits of generator test log. The results of audits will be reviewed in QAA and determination will be made for continued audits. Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 154 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service	K 154	Maintenance Director completed a thorough search of records and was able to locate the Automatic Fire Sprinkler System Out of Service Policy. The policy was reviewed and is accurate.	10/15/15

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THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

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K 154	Continued From page 14 for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all residents, visitors and staff of the facility. Findings include: On facility tour between 10:30 AM to 2:30 PM on 09/21/2015, during record review and an interview with the facility manager, it was found that the facility could not provide a complete automatic fire sprinkler system out of service policy. This deficient condition was verified by the Maintenance Director (MC).	K 154	Director of Maintenance and/or designee will be responsible for ongoing compliance.	
K 155 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability	K 155	Maintenance Director completed a thorough search of records and was able to locate the Automatic Fire Alarm System Out of Service Policy. The policy was reviewed and is accurate. Director of Maintenance and/or designee	10/15/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **02 - THE MARGARET S. PARMLEY RESIDENCE** B. WING ______	**09/21/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

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K 155	Continued From page 15 for early response and notification of a fire and would affect the safety of all residents, visitors and staff of the facility. Findings include: On facility tour between 1:30 PM and 3:30 PM on 07/14/2015, during record review and an interview with the facility manager, it was found that the facility could not provide a complete automatic fire alarm system out of service policy. This deficient practice was verified by the Facility Manager.	K 155	will be responsible for ongoing compliance.	

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

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

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

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

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

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

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00065	A. BUILDING: ________ B. WING ________	09/17/2015

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

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 AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00065	A. BUILDING: ______ B. WING ______	09/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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2 000	Continued From page 1	2 000		

Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

On September 14th-17th, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.

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

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, facility failed to provide assistance with eating and repositioning in accordance with care plan for 1 of 1 resident (R16) reviewed for hospice. Findings include: Eating: 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 breakfast." -At 8:37 a.m. R16 had a covered cup with a spout of milk and red juice on tray. R16 was able to lift	2 565	Corrected	10/15/15

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2 565	Continued From page 3	2 565		

Continued From page 3

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 stated to surveyor, "I ask for help and they say they are too busy."

During continuous observation on 9/16/15, from 7:20 a.m. until 11:00 a.m. were as follows:
-At 7:20 a.m. R16 was still seated in wheelchair in front of over the bed table. R16 stated was waiting for breakfast.
-At 7:58 a.m. Breakfast trays arrived in unit on cart.
-At 8:06 a.m. R16 sitting in room, tray table in front of resident. Breakfast tray had not been delivered.
-At 8:28 a.m. NA-A took tray in to R16's room.
-At 8:29 a.m. R16 was heard ask NA-A, "can you please help me with breakfast?" NA-A replied, "I will come back and help you if I have the time after I pass the rest of the trays and get someone else up." R16 sat in front of the table with the tray food.
-At 8:34 a.m. all room trays had been passed.
- At 8:40 a.m. when asked how was breakfast? R16 stated, "It was good once I got it. I have been sitting here for over an hour before they brought it. I asked for help to eat, but she never came back. It is so hard and I spill on myself. I hate it when I do that."
-At 8:55 a.m. registered nurse (RN)-B removed tray from room. R16 had eaten 100 percent of hot cereal and had drunk a quarter of cup of milk.

R16's nutritional status care plan revised on 7/17/15, indicated "resident is requesting room trays and feeding assist most meals."

R16's activities of daily living (ADLs) care plan revised 8/7/15, indicated, "The resident requires

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2 565	Continued From page 4	2 565		

extensive assistance of 1 staff to eat."

Diagnoses for R16 from Admission Record dated 9/16/15, include but not limited to dysphagia (difficulty swallowing) due to cerebrovascular disease (stroke), muscle weakness, major depression, fatigue and anxiety.

Undated/unlabeled Nursing Assistant Assignment sheet for R16 indicated, "Assist of 1 for all ADLs."

On 9/16/15, at 11:05 a.m. RN-B stated "If [R16] asks for assistance they are to help her or at least sit there." [R16] chooses to eat in room. [R16] is ok with understanding, if eats in room, [R16] may have to do feed herself. People who need assistance are in the dining room. It is difficult with [R16], some days are good and some days are not so good because of [R16's] tremor. We arranged for the hospice aide to feed her lunch. We may need to revisit with [R16] eating in the dining room if [R16] needs help eating. Trays are to be passed within 15 minutes.

On 9/17/15 at 11:23 a.m. director of nursing (DON) stated, "My expectation is anytime a resident asks for help you help them. She has a tremor and may need help. It is on and off. Sometimes she needs help sometimes she can do it herself." She requires per care plan extensive assistance of one to eat. "She should not have to ask for assistance to eat based on this." When asked if your staff providing her with the assistance and cares she needs? DON replied, "No. I will be filing a vulnerable adult report on this."
Policy for providing assistance with eating was requested from facility but not provided.
Repositioning:
During continuous observation on 9/16/15, from

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THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013**

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2 565	Continued From page 5 7:08 a.m. until 11:00 a.m. -7:08 a.m. R16 up in wheelchair getting her hair combed. -7:35 a.m. R16 sitting in wheel chair. -7:50 a.m. R16 sitting waiting for breakfast. -8:28 a.m. NA-A took tray in to R16 room. NA-A did not reposition R16. -8:55 a.m. RN-B picked up tray. RN-B did not reposition R16. -9:09 a.m. R16 wheeled herself slowly toward her bed. -9:15 a.m. RN-A talking with R16 in R16's room. -9:33 a.m. RN-A still in room. R16's position unchanged. -9:44 a.m. the beautician took R16 to the beauty shop. -9:54 a.m. R16 sitting in wheelchair with her eyes closed. There was a cushion in the wheelchair that was approximately three inches thick. R16 did not shift buttocks. -10:13 a.m. R16 sitting under the drier. R16 had not changed positions. -10:53 a.m. the beautician brought R16 back to room. -11:00 a.m. R16's bottom was observed with the assistance of NA-C, during transfer from wheel chair to toilet. Bottom was purple red from top of coccyx to peri area extending outward on buttock approximately five centimeters (cm) on either side of center. No Open areas were observed. The area did not appear to have a rash. The incontinent product was dry. The area blanched when NA pressed on area to clean skin. NA-C stated, "this is redder than she normally is." Pressure ulcer care area assessment dated 4/27/15, indicates "Resident is at risk for skin break down r/t [related/to] friction/shear potential, varied oral intakes, advance age, and decreased mobility."	2 565		

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2 565	Continued From page 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.

On 9/16/15, at 11:05 a.m. RN-B stated, R16's skin was red but blanchable there were no non blanchable pressure areas. She has a fungal infection that we are treating with Nystatin cream and more absorbent brief. RN-B stated "my expectation for repositioning is if there is a current pressure ulcer every one hour, otherwise at least offer every two hours."

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2 565	Continued From page 7 On 9/17/15, at 11:23 a.m. the DON stated, "the expectation was [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 are your staff providing her with the assistance and cares she needs? DON replied,"No. I will be filing a vulnerable adult report on this." SUGGESTED METHOD OF CORRECTION: The DON or designee (s)could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee (s)could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
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

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2 570	Continued From page 8 the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, facility failed to update the care plan after falls for 1 of 4 resident (R21) reviewed for accidents. 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. On 9/16/15, at 2:00 p.m. nursing assistant (NA)-I was interviewed and when asked what she did to prevent R21 from falling NA-I stated "I talk to [R21] a lot, provide distractions, spend time with her. [R21] likes to stack things. Therapy is working with [R21]. Walking would benefit her. She does try to stand up on her own." On 9/17/15, at 7:48 a.m. was interviewed and R21 stated, "I bruise easily, I must have fallen." R21's care plan dated 8/18/15, indicated R21 had potential for injury (falls) related to impaired physical mobility, cognitive impairment, medication use. The care plan interventions included adjust bed to appropriate height, gripper socks, assist of for all transfers/ ambulation, assistive devices as needed (PRN), fall precautions PRN, transfer belt with all transfers, call light within reach, remind every shift to call for help and not to be left unattended in bathroom.	2 570	Corrected	

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2 570	Continued From page 9	2 570		

R21's medical record was reviewed and the following noted R21 had fallen on 8/23/15, 8/29/15, and 9/6/15. Even though interventions had been developed following each of the falls of which two had significant injuries R21's care plan had not been updated to reflect the interventions. The falls were as follows:
-Confidential Peer Review Document Resident Incident Report dated 8/23/15, indicated, R21 was found sitting on floor of the dining room and had sustained a skin tear on the left index finger and a 12 centimeter (cm) long by 4 cm deep gash to the left forearm. The report indicated immediate interventions implemented to prevent further falls were, to continue bowel and bladder monitoring to establish patterns to develop a bowel and bladder program, R21 was given a different wheelchair and labs for baseline status were done. R21 did receive a new w/c and the labs had been completed. Even though R21 was care planned to be toileted every two hours, the facility did not develop and implement an individualized program for bowel and bladder after the fall.

-Confidential Peer Review Document Resident Incident Report dated 8/29/15, indicated, NA found R21 lying on the floor in the day room. No injury indicated. The report indicated interventions implemented were, to continue physical therapy (PT) and occupational therapy (OT) to address wheelchair positioning and the nurse practitioner or doctor was to review blood pressure's due to elevation. The medical review noted the physician had checked the blood pressures. Although, R21 received PT/OT, the care plan was not revised to reflect the therapies.

-Confidential Peer Review Document Resident

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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
2 570	Continued From page 10	2 570		

Incident Report dated 9/6/15, indicated, R21 was witnessed bending over reaching to the floor in Martha's dining room and fell to the floor hitting the head. R21 had sustained a 3 cm laceration and large bump to forehead with bruising. The report interventions implemented were for OT to assess R21 for a tilt in space wheelchair, assess for vision field cut and to continue to work with R21 on safety and PT was to continue to work with R21 on balance and strengthening. Although R21 received OT, the medical record was void of any information regarding the assessment of the field cut. The tilt and space w/c was not added to the plan of care.

R21's diagnoses included dementia, hypertension, other fracture, lumbago, peripheral retinal degeneration and difficulty walking obtained from the admission Minimum Data Set (MDS) dated 8/25/15. The MDS also indicated R21 was severely cognitively impaired and required assistance with activities of daily living (ADL). In addition the MDS indicated R21 had fallen since admission or the prior assessment and had a fracture related to a fall in the six months prior to admission.

On 9/17/15, at 8:18 a.m. registered nurse (RN)-C stated, falls are reviewed by the interdisciplinary team (IDT). RN-C indicated after a progress note had been done and the care plan was supposed to be updated. RN-C verified the care plan had not been updated with new fall interventions since admission and even though R21 had sustained two significant injuries since admission at the facility.

Care Plans-Comprehensive policy revised October 2010 directed staff:
"An individualized comprehensive care plan that

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2 570	Continued From page 11 includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident ... " In addition the policy indicated: " 8. Assessments of residents are ongoing and care plans are revised as information about the resident's condition change...." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise policies/procedures for the revision of care plans, educate staff and perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 570		
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel;	2 625		10/15/15

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2 625	Continued From page 12 F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This MN Requirement is not met as evidenced by: Citation Text for Tag 0514, Regulation FF09 Jares, Magdalene Based on interview and record review, the facility failed to maintain accurate medical records were complete for 5 of 5 residents (R32, R81, R41, R127, R197) and 2 of 2 discharged residents (R99, R70) reviewed for monthly pharmacist reviews.	2 625	Corrected	

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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

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2 625	Continued From page 14	2 625		

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, February 2015, March 2015, April 2015, May 2015 and June 2015, July 2015, August 2015.
Review of the Consultant Pharmacist's Parmly

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2 625	Continued From page 15 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 four noted irregularities and/or recommendations for R127. There were no consultant pharmacist's Medication Regimen Review recorded by the pharmacist in R127's chart. R197's diagnoses included Alzheimer disease, dementia with behavioral disturbances, polymyalgia rheumatica, and neuropathy, obtained from Admission Record dated 9/17/15. R197 was admitted 8/4/15. There was no consultant pharmacist's Medication Regimen Review available in the medical record for October 2014, December 2014, January 2015, February 2015, March 2015, April 2015, May 2015 and June 2015, July 2015, August 2015. Review of the Consultant Pharmacist's Parmly Lifepointes Summary Reports kept in a binder in the director of nursing office dated 8/2015, showed four irregularities for the doctor to address during medication reconciliation. On 9/17/15, at 9:00 a.m. the DON received the multi-patient monthly medication reviews, they cannot be placed in the individual patient medical records because they contain other patients names. The blank and undated Thrifty White Pharmacy Services Monthly Medication Regimen Reviews form was in the Consultant Pharmacist File (white 3 ring binder), but was not being used at the facility. DISCHARGED RESIDENTS R99's diagnoses included chronic pancreatitis, chronic airway obstruction, osteoporosis and malignant neoplasm upper lobe bronchus	2 625		

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2 625	Continued From page 16	2 625		

obtained from Admission Record dated 9/17/15.

R99 was admitted to the facility 5/23/15, and remained in the facility until 7/5/15. Review of Parmly Lifepointes Summary Reports, indicated the last consultant pharmacist review in the medical record was dated 6/2/15. There was no consultant pharmacist's Medication Regimen Review recorded by the pharmacist for June 2015 in R99's chart.

R70's diagnoses included anxiety, bipolar I disorder, insomnia, osteoporosis, hypertension, and cerebrovascular disease obtained from physician order record dated 5/15/15.

R70 was admitted to the facility 4/24/15 and remained in the facility until 6/8/15. Review of Parmly Lifepointes Summary Reports, indicated the last consultant pharmacist review in the medical record was dated 6/2/15. There was no consultant pharmacist's Medication Regimen Review recorded by the pharmacist for either May 2015, or June 2015 in R70's chart.

On 9/17/15, at 3:44 p.m. the consultant was called no answer.

On 9/17/15, at 11:00 a.m. the HIM director verified that monthly medication reviews should be in the individual charts, and used to be in the charts, but have not been since the new pharmacist took over.

On 9/17/15, at 3:44 p.m. a voicemail was left for the consultant Pharmacist (CP). On 9/18/15, at 1:30 p.m. the CP returned the call and stated the summary is collated onto a computer form, electronically and emailed or handed to the

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2 625	Continued From page 17 director of nursing, and that this process had been vetted by his director. The CP verified that the monthly medication review was not in each individual residents chart, since it was a collated summary. The monthly medication review information was produced and maintained on a pharmacy based system and was not available within each individual residents medical record. The DON was provided a copy of each visit by the consultant pharmacist. The form contained the information of multiple patients monthly chart reviews, the consultant pharmacist visited the facility twice a month to complete all of the monthly reviews. To review an individual patients monthly medication review for the prior 12 months would involve looking at two printouts per month to find the residents medication changes (24 documents, and then the summary of recommendations, additional pages which number varied by month). The Medication Regimen Review (Monthly Report) Policy indicated.... The CP perform a comprehensive medication regimen review (MMR) at least monthly. The MMR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. Findings and recommendations are reported to the director of nursing and the attending physician, and if appropriate the medication director and/or administrator... The facility lacked the necessary monthly medication reviews available in the individual resident chart, and in the closed medical records.	2 625		

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2 625	Continued From page 18 SUGGESTED METHOD FOR CORRECTION: The DON and/or designee could monitor to assure the maintenance of accurate, complete, and organized clinical information about each resident. The DON or designee could also perform audits of resident records and report findings to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 625		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, failed to provide assistance with eating for 1 of 1 resident (R16) who was reviewed for hospice. Findings include:	2 830	Corrected	10/15/15

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2 830	Continued From page 19	2 830		

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 breakfast."
-At 8:37 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 on the white cloth that covered the chest. When approached R16 stated to surveyor, "I ask for help and they say they are too busy."

During continuous observation on 9/16/15, from 7:20 a.m. until 11:00 a.m. were as follows:
-At 7:20 a.m. R16 was still seated in wheelchair in front of over the bed table. R16 stated was waiting for breakfast.
-At 7:58 a.m. Breakfast trays arrived in unit on cart.
-At 8:06 a.m. R16 sitting in room, tray table in front of resident. Breakfast tray had not been delivered.
-At 8:28 a.m. NA-A took tray in to R16's room.
-At 8:29 a.m. R16 was heard ask NA-A, "can you please help me with breakfast?" NA-A replied, "I will come back and help you if I have the time after I pass the rest of the trays and get someone else up." R16 sat in front of the table with the tray food.

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2 830	Continued From page 20	2 830		

-At 8:34 a.m. all room trays had been passed.
- At 8:40 a.m. when asked how was breakfast? R16 stated, "It was good once I got it. I have been sitting here for over an hour before they brought it. I asked for help to eat, but she never came back. It is so hard and I spill on myself. I hate it when I do that."
-At 8:55 a.m. registered nurse (RN)-B removed tray from room. R16 had eaten 100 percent of hot cereal and had drunk a quarter of cup of milk.

The Care Area Assessment (CAA) dated 4/22/15, indicated "...is eating most meals in her room and requesting help with feeding."

R16's nutritional status care plan revised on 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.

R16's activities of daily living (ADLs) care plan revised 8/7/15, indicated, "The resident requires extensive assistance of 1 staff to eat."

Diagnoses for R16 from Admission Record dated 9/16/15, include but not limited to dysphagia (difficulty swallowing) due to cerebrovascular disease (stroke), muscle weakness, major depression, fatigue and anxiety.

The Weights and Vitals Summary printed on 9/17/15, indicated R16's weight on 5/3/15, was 156.1 and on 9/11/15, was 150.4 pounds. R16 had lost approximately 5.7 pounds in four months.

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2 830	Continued From page 21	2 830		

On 9/16/15, at 9:32 a.m. NA-A stated, ..."the family made arrangements for the hospice aide to come in at noon to feed [R16]. [R16] needs help eating. [R16] asked for help today and I told her I will back, but I was too busy."...
On 9/16/15, at 11:05 a.m. RN-B stated "If [R16] asks for assistance they are to help her or at least sit there." [R16] chooses to eat in room. [R16] is ok with understanding, if eats in room, [R16] may have to do feed herself. People who need assistance are in the dining room. It is difficult with [R16], some days are good and someday's are not so good because of [R16's] tremor. We arranged for the hospice aide to feed her lunch. We may need to revisit with [R16] eating in the dining room if [R16] needs help eating. Trays are to be passed within 15 minutes.

On 9/17/15, at 11:23 a.m. director of nursing (DON) stated, "My expectation is anytime a resident asks for help you help them. She has a tremor and may need help. It is on and off. Sometimes she needs help sometimes she can do it herself." She requires per care plan extensive assistance of one to eat. "She should not have to ask for assistance to eat based on this." When asked are your staff providing her with the assistance and cares she needs? DON replied,"No. I will be filing a vulnerable adult report on this." R16 did not receive the care and services to maintain good nutritional status. Policy for providing assistance with eating was requested from facility but not provided.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review the facility policy for assessment of resident nutritional needs, and make any needed changes to reflect current eating abiliites. The

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2 830	Continued From page 22 DON could in-service staff on nutritional needs and about how to correctly implement a resident's plan of care. The DON could then audit these to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide necessary assistance with repositioning for 1 of 1 resident (R16) identified at risk of developing pressure ulcers that was reviewed for hospice. Findings include: During continuous observation on 9/16/15, from 7:08 a.m. until 11:00 a.m. and the following was noted: -7:08 a.m. R16 up in wheelchair getting her hair combed. -7:35 a.m. R16 sitting in wheel chair. -7:50 a.m. R16 sitting waiting for breakfast. -8:28 a.m. nursing assistant (NA)-A took tray in to	2 905	Corrected	10/15/15

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THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

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2 905	Continued From page 23	2 905		

R16 room. NA-A did not reposition R16
-8:55 a.m. registered nurse (RN)-B picked up tray. RN-B did not reposition R16.
-9:09 a.m. R16 wheeled herself slowly toward her bed.
-9:15 a.m. RN-A talking with R16 in R16's room.
-9:33 a.m. RN-A still in room. R16's position unchanged.
-9:44 a.m. Beautician took R16 to the beauty shop.
-9:54 a.m. R16 sitting in wheelchair with her eyes closed. There was a cushion in the wheelchair that was approximately three inches thick. R16 did not shift buttocks.
-10:13 a.m. R16 sitting under the drier. R16 had not changed positions.
-10:53 a.m. Beautician brought R16 back to room.
-11:00 a.m. R16's bottom was observed with assistance of NA-C, during transfer from wheel chair to toilet. Bottom was purple red from top of coccyx to peri area extending outward on buttock approximately five centimeters (cm) on either side of center. No Open areas were observed. The area did not appear to have a rash. The incontinent product was dry. The area blanched when NA pressed on area to clean skin. NA-C stated, "This is redder than she normally is."

Pressure ulcer care area assessment dated 4/27/15, indicated "Resident is at risk for skin break down r/t [related/to] friction/shear potential, varied oral intakes, advance age, and decreased mobility."

R16's quarterly 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 all activities of daily living including mobility.

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2 905	Continued From page 24	2 905		

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."

The 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 needs help. R16 was to be repositioned every two hours.

On 9/16/15, at 11:05 a.m. RN-B stated, "[R16's] skin is red but blanchable there are no non blanchable pressure areas. She has a fungal infection that we are treating with Nystatin cream and more absorbent brief." RN-B stated "My expectation for repositioning is if there is a current pressure ulcer every one hour, otherwise at least offer every two hours."

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2 905	Continued From page 25 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.	2 905		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence 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	2 910		10/15/15

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2 910	Continued From page 26 comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. 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. Findings include: R176 was observed on 9/16/15, at 8:38 a.m. being wheeled into the dining room by nursing assistant (NA)-G. As NA-G wheeled R176 around the table to adjust R176's wheelchair (W/C), R176 was observed to grab on his crotch, facially grimaced as if in pain, and indicated something was pulling on the catheter tubing. Underneath the W/C, lying on the floor, was the catheter tubing coiled and caught under the left front wheel. The catheter bag was stored inside a blue bag under the W/C, however the tubing was left out and was dragged on the floor. NA-G stopped immediately, bent over and looked under the W/C. NA-G was then observed to lift the front portion of the W/C to get the tubing off the front	2 910	Corrected	

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2 910	Continued From page 27	2 910		

wheel and tucked the tubing into the blue bag under the W/C. NA-G continued to wheel R176 to his table then was observed speak briefly to R176 then went over to wash hands. No blood was noted in the catheter tubing.

On 9/17/15, at 7:50 a.m. even after concern had been brought to the attention of the unit manager R176 was observed seated on the W/C across from the nursing station approximately four feet from the medication cart and the catheter tubing was observed lying on the floor under the W/C and the tubing was close to the left front W/C wheel approximately three centimeters. At the time observed several staff walk past R176 and never offered or addressed to adjust the catheter tubing.

R176's diagnoses included difficulty walking, hypertrophy prostate with urinary obstruction and other lower symptoms, personal history of urinary tract infections and chronic kidney disease stage III obtained from the MD/Nursing Communications sheet dated 8/20/15.

R176's urinary incontinence and indwelling catheter Care Area Assessment (CAA) dated 9/1/15, indicated R176 was to be free of trauma related to indwelling catheter and staff was to observed and monitor. R176's care plan dated 8/2/15, identified R176 had an indwelling catheter related to benign prostatic hyperplasia (BPH) with obstruction and urine retention. The care plan directed staff to position the catheter bag and tubing below the level of the bladder and away from entrance room door and check the tubing for kinks with cares each shift.

R176's Physician Order signed but undated, revealed an order for a Foley catheter 16 French

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2 910	Continued From page 28	2 910		

with 5-10 cc balloon.

On 9/16/15, at 12:05 p.m. registered nurse (RN)-E unit nurse manager stated staff were going to be educated about it. She indicated the catheter bag was not supposed to be positioned that way and the staff was supposed to ensure the extra tubing was in the bag to prevent being caught by the wheel. RN-E acknowledged she was going to check R176 to make sure the penis had not been injured as a result of being pulled on that morning.

On 9/16/15, at 11:40 a.m. NA-G was interviewed to follow up on the observation she stated she had assisted R176 to get ready that morning and transferred him into the wheelchair and she thought she had tucked the extra tubing into the blue bag under the W/C. When asked if there was something like a clip that was used to secure the tubing to make sure it does not roll out she stated "Sometimes they don't hold well you know what am saying."

R159 was observed on 9/15/15, at 1:28 p.m. seated on her wheelchair (W/C) in the common area in front of the television (TV) and the urinary catheter bag was observed stored inside a blue bag under the W/C but the extra tubing approximately two and a half (2 ½) feet was observed lying on the floor not covered and the tubing was noted to have yellow urine along the entire visible length.
-At 1:37 p.m. activity staff (A)-A wheeled R159 off the unit as she stated to R159 she was going to bring her to the dining room for the monthly birthday party. As A-A wheeled R159 off the unit the catheter tubing was noted dragging on the floor exposed and yellow urine was observed

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2 910	Continued From page 29	2 910		

along the length still.
-At 1:40 p.m. to 2:52 p.m. R159 was observed in the dining room (DR) seated at the table catheter tubing still lying on the floor with 2 and ½ feet of the tubing visible. While observing R159 from the hallway outside the DR several staff went past R159 W/C and did not conceal the tubing.

On 9/16/15, at 7:00 a.m. R159 was observed seated on the W/C in front of the television in the common area. When approached and asked how she was doing R159 stated was doing well and had slept "pretty good." At the time R159 was observed all dressed and the catheter tubing was lying again on the floor with yellow urine noted on the entire approximately (2 ½) feet and the catheter bag was stored in the blue bag underneath the W/C and a plastic black clip was just hanging along the length of tubing.
-At 8:23 a.m. the health unit coordinator (HIC) wheeled R159 off the unit with the catheter tubing still lying on the floor dragging along.
-At 8:33 a.m. R159 was seated on her W/C at the DR table with the catheter tubing still lying on the floor in the dining room.
-At 9:13 a.m. R159 was observed being wheeled out of the DR to the unit with the catheter tubing being dragged on the floor.
-At 9:16 a.m. A-A was observed wheel R159 into the chapel catheter tubing still dragging on the floor.
- At 10:50 a.m. R159 was observed seated on the W/C in the common area across from the nursing station the catheter tubing lying on the floor visible. When standing at the nursing station several staff went past R159's W/C including nurses and NA's none offered to store it properly.

On 9/17/15, at 7:50 a.m. even after concern had been brought to the unit managers attention on

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2 910	Continued From page 30	2 910		

9/16/15, R159 was observed seated on her W/C across from the nursing station, when approached the catheter tubing was observed lying on the floor under the W/C. When approached and asked if the catheter tubing being exposed bothered her R159 did not respond but smiled and continued to run her finger through a stuffed dog she was holding.

R159's diagnoses included dementia without behaviors, Alzheimer's disease, muscle weakness, unspecified retention of urine, neurogenic bladder and urinary obstruction obtained from MD/Nursing Communication sheet dated 9/9/15.

R159's Physician Order dated 9/9/15, revealed an order for a Foley catheter 16 French with 10 cubic centimeter (cc) balloon.

R159's care plan dated 8/31/15, identified R159 had an indwelling catheter related to urinary retention secondary to neurogenic bladder. The care plan directed staff to position the catheter bag and tubing below the level of the bladder and away from entrance room door and check the tubing for kinks with cares each shift.

On 9/16/15, at 10:50 a.m. nursing assistant (NA)-F stated she has assisted R159 with all the cares which included catheter cares and had done a quick swipe on the catheter as R159 would pinch during cares.

On 9/16/15, at 12:05 p.m. registered nurse (RN)-E unit nurse manager verified the catheter was lying on the floor stated it was a dignity issue and the staff were going to be educated about it. She indicated the catheter bag was not supposed to be positioned that way and the staff was

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2 910	Continued From page 31 supposed to ensure the extra tubing was in the bag to prevent being caught by the wheel. RN-E further stated if the staff had identified the plastic clip was not able to secure the tubing to prevent it from rolling out of bag the NAs were supposed to report to the nurse immediately and a new bag with tubing would be changed. On 9/17/15, at 9:06 a.m. the director of nursing (DON) stated the catheter tubing should be off the floor and be under the chair hang and in the bag. DON further stated "the tubing should not be that long" to prevent the tubing from being caught and also thought was an infection control issue. Both R176 and R159 did not receive the necessary care and services for the catheter tubing placment as to avoid potential impaired bladder function. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could inservice staff regarding the proper care of catheter use. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 910		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by:	21015		10/15/15

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Based on observation, interview and document review the facility failed to follow equipment sanitation procedures that would minimize the possibility of food borne illness. This had the potential to affect 85 of 87 residents in the facility, which was served food out of the kitchen.

Corrected

Findings include:

During kitchen tour on 9/14/15, at 1:00 p.m. the following sanitation concerns were observed and confirmed by the director of nutrition services (DNS):

- four burner stove had a heavy buildup of a black substance on the front top aluminum piece (approximately 1" width X 24" length), right side of the stove (1/2" width X 18" length) and on the backsplash to the back of the stove. The corners of the cast iron stove top grates had a buildup of a greasy black substance. The oven door below the four burner stove had a buildup of a brown greasy substance on and around the handle and sides of the door. DNS verified it needed to be cleaned and stated major oven cleaning is completed on the weekends.

- ice machine on the PAC (transitional care) unit across from the kitchenette was dripping out of the ice shoot and noted to have stagnant water in the catch basin. DNS stated that maintenance and housekeeping were responsible for these ice machines.

- ice machine on Parkside unit in the hallway across from nursing station was dripping out of the ice shoot and noted to have stagnant water in the catch basin which was not draining.

During a follow-up kitchen tour on 9/16/15, at

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10:15 a.m. the following sanitation concerns were observed and verified by the DNS:

- Ice machine in the kitchen had a buildup of a brown substance on the right side of the door and on the inside front of the machine. When the door was closed the substance was directly above the holding bin of ice used for resident use. This brown substance was easily removed and verified by the DNS.

- Garbage disposal that was part of the food preparation table had extensive piping located to the left of the disposal. There was a heavy buildup of black/brown mix of dirt and food type substance on and around an approximate two inch diameter pipe that went into the flooring, all piping going to the left and right of it and around connecting joint surfaces. An electric outlet was dirty with heavy dust/dirt buildup next to the piping surfaces. Piping directly connected to the water valve to the left of the garbage disposal closer to the top of the food preparation table was heavily soiled with dirt/food debris. When the debris buildup was scraped with a spatula, the DNS stated she was not sure what the substance was and verified it should have been cleaned.

- Kitchen steam table drainage hose approximately four feet in length was hanging wrapped on a hook to the right of the unit. The lower 24 inches of the hose was taped to a hard piece of material with frayed, heavily soiled red duct tape. This lower section was the area that dietary workers touched to drain the hose after each meal use.

- Two 4" X 4" square wall tiles were missing on the outside portion of the wall located behind the convection oven.

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21015	Continued From page 34 During environmental tour on 9/17/15, at 9:50 a.m. with the director of maintenance (DM) the following was observed: - Ice machine on the PAC unit was still dripping out of the ice shoot, the drain in the catch basin was plugged and it was filled with stagnant water. A resident wash basin was under the ice shoot collecting the dripping water and was noted to be approximately 1/4 full. DM stated the machine is plugged up daily and they have a system to clean it out weekly. - Ice machine on the Parkside unit was now draining however water still was dripping down the ice shoot was. During an interview on 9/17/15, at 7:43 a.m. the DNS stated the kitchen ice machine was not on the cleaning schedule but maintenance cleaned it last month. However, the former maintenance staff wiped the records clean thus there was no documentation to verify this. Review of the kitchen cleaning schedules for May thru September 12, 2015 indicated the stove top, bottom oven and oven fronts were cleaned weekly verified by staff initials. The kitchen ice machine was not listed on the cleaning assignment sheets. No cleaning schedules from maintenance were provided. The facility Cleaning Instructions: Ice Machine and Equipment dated 2010, indicated the ice machine and equipment (scoops) will be cleaned on a regular basis to maintain a clean, sanitary condition by removing the ice and washing the interior and exterior of the machine thoroughly using a detergent solution.	21015		

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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
21015	Continued From page 35 The facility Cleaning Instructions: Ranges and Ovens dated 2010, indicated the ovens will be cleaned as needed and according to the cleaning schedule (at least once every two weeks). No policy was provided for cleaning the stove top and surrounding area. SUGGESTED METHOD OF CORRECTION: The dining director (DD) or designee could develop, review and/or revise policies and procedures to ensure kitchen equipment is cleaned. The DD or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21015		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility did not ensure adequate sound levels were provided for 1 of 1 resident (R45) reviewed for environmental concerns and the facility failed to ensure the environment was maintained in a safe manner for 5 of 8 residents (R66, R198, R104, R106, R8) reviewed for environmental concerns. Findings include:	21665	Corrected	10/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00065	A. BUILDING: ______ B. WING ______	09/17/2015

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21665	Continued From page 36 On 9/14/15, at 12:27 p.m. during interview when R45 was asked if she any problems with the temperature, lighting, noise or anything else in the building that affected your comfort, R45 stated the air conditioner over her recliner in her room was noisy and cold. R45 further stated she had talked to the facility and thought they had tried to reset her thermometer in the room but it did not always work. R45's quarterly Minimum Data Set (MDS) dated 9/1/15, indicated R45's cognition was intact and had minimal hearing difficulty. On 9/17/15, at 9:30 a.m. during the environmental tour with the director of maintenance (DM), a loud noise was observed coming out of above head cooling system which was right over R45 as she sat in her recliner. During the tour R45 stated "it is loud, too noisy." The DM verified the issue and stated "it is fixable, it is a flow valve." When asked if the facility performed routine audits DM indicated random audits were done but "there is no documentation on audits." DM further stated every staff had the ability to put work orders in the TELS system (an online campus wide work order system) and staff should report any issue and can even choose priority from immediate too low. R66 and R198's room had frayed, ragged gray duct tape approximately five feet in length used to secure a seam on the vinyl flooring. The area was in the center of the first bedroom as you enter the room. On the same seam in the second bedroom, approximately 1/4 inch by one foot in length of the vinyl flooring was broken off and missing creating a potential tripping hazard. Both areas created an uncleanable surface. DM stated they would need to strip the vinyl, glue the seam and rewax the floor. DM verified both areas need	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00065	A. BUILDING: ____ B. WING ____	09/17/2015

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21665	Continued From page 37	21665		

to be repaired.

R66's quarterly Minimum Data Set (MDS) dated 8/29/15, indicated R66 had severely impaired cognition and required extensive assistance with most activities of daily living (ADL's).

R198's admission MDS dated 8/11/15, indicated R198 had severely impaired cognition and required extensive assistance with most ADL's.

R104 and R106's room had gray duct tape, approximately five feet in length used to secure a seam on the vinyl flooring located at the entrance of the room. DM stated "staff put tape on it because they may have thought it was unsafe."

R104's annual MDS dated 5/16/15, indicated R104 had severely impaired cognition, required extensive assistance with most ADL's and had a care area assessment trigger for falls.

R106's quarterly MDS dated 7/4/15, indicated R106 had severely impaired cognition and required extensive assistance with most activities of daily living (ADL's).

R8's room had gray duct tape, approximately five feet in length used to secure a seam in the vinyl flooring located at the entrance of the room.

R8's quarterly MDS dated 6/15/15, indicated R8 had severely impaired cognition and required extensive assistance with most ADL's.

During an interview on 9/17/15, at 10:46 a.m. DM stated maintenance looked at the TELS system hourly for any issues. DM stated "it is a very easy system to use and they go over it in new employee training."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00065	A. BUILDING: ______ B. WING ______	09/17/2015

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21665	Continued From page 38 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.	21665		