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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZUXG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00125

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245528**
2.STATE VENDOR OR MEDICAID NO.
(L2) **978740200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GUNDERSEN HARMONY CARE CENTER**
(L4) **815 MAIN AVENUE SOUTH**
(L5) **HARMONY, MN** (L6) **55939**

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 **1/4/2014** (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 **43** (L18)

13.Total Certified Beds **43** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43			
(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 :
Gary Nederhoff, Unit Supervisor 01/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/10/2014 (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
04/01/1988
(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
01/24/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5528

This facility was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on November 15, 2013. On January 4, 2014, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on December 23, the Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on November 15, 2013, effective December 25, 2013. Refer to the CMS-2567B for both health and life safety code.

Effective December 25, 2013, the facility is certified for 43 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number: 24-5528

March 10, 2014

Mr. Timothy Samuelson, Administrator
Gundersen Harmony Care Center
815 Main Avenue South
Harmony, Minnesota 55939

Dear Mr. Samuelson:

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 December 25, 2013, the above facility is certified for:

43 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 43 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245528	A. Building B. Wing	1/4/2014

Name of Facility	Street Address, City, State, Zip Code
HARMONY COMMUNITY HEALTHCARE INC	815 MAIN AVENUE SOUTH HARMONY, MN 55939

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0159 Reg. # 483.10(c)(2)-(5) LSC	Correction Completed 12/20/2013	ID Prefix F0176 Reg. # 483.10(n) LSC	Correction Completed 12/25/2013	ID Prefix F0274 Reg. # 483.20(b)(2)(ii) LSC	Correction Completed 12/20/2013
ID Prefix F0315 Reg. # 483.25(d) LSC	Correction Completed 12/25/2013	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 12/20/2013	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 12/25/2013
ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 12/25/2013	ID Prefix F0428 Reg. # 483.60(c) LSC	Correction Completed 12/25/2013	ID Prefix F0431 Reg. # 483.60(b), (d), (e) LSC	Correction Completed 12/20/2013
ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 12/25/2013	ID Prefix F0465 Reg. # 483.70(h) LSC	Correction Completed 12/25/2013	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	16022	1-22-14	10160	1-3-14
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?
11/15/2013	YES NO

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
245528	A. Building B. Wing 01 - MAIN BUILDING	12/23/2013

Name of Facility	Street Address, City, State, Zip Code
HARMONY COMMUNITY HEALTHCARE INC	815 MAIN AVENUE SOUTH HARMONY, MN 55939

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix ____ Reg. # NFPA 101 LSC K0050	Correction Completed 12/20/2013	ID Prefix ____ Reg. # NFPA 101 LSC K0052	Correction Completed 12/20/2013	ID Prefix ____ Reg. # NFPA 101 LSC K0069	Correction Completed 12/20/2013
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed

Reviewed By State Agency	Reviewed By 16022	Date: 1-22-14	Signature of Surveyor: 25822	Date: 12-23-13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 11/13/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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
245528	A. Building 01 - MAIN BUILDING B. Wing	12/23/2013

Name of Facility	Street Address, City, State, Zip Code
HARMONY COMMUNITY HEALTHCARE INC	815 MAIN AVENUE SOUTH HARMONY, MN 55939

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix ____ Reg. # NFPA 101 LSC K0050	Correction Completed 12/20/2013	ID Prefix ____ Reg. # NFPA 101 LSC K0052	Correction Completed 12/20/2013	ID Prefix ____ Reg. # NFPA 101 LSC K0069	Correction Completed 12/20/2013
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed
ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed	ID Prefix ____ Reg. # ____ LSC ____	Correction Completed

Reviewed By State Agency ____	Reviewed By 16022	Date: 1-22-14	Signature of Surveyor: 25822	Date: 12-23-13
Reviewed By CMS RO ____	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/13/2013

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 22, 2014

Mr. Timothy Samuelson, Administrator
Harmony Community Healthcare Inc
815 Main Avenue South
Harmony, MN 55939

RE: Project Number S5528024

Dear Mr. Samuelson:

On December 5, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 15, 2013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 4, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 23, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 15, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 20, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 15, 2013, effective December 25, 2013 and therefore remedies outlined in our letter to you dated December 5, 2013, will not be imposed.

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. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Gary Nederhoff

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Telephone: 507-206-2731 Fax: 507-206-2711

Enclosure: cc Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZUXG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00125

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245528**
2.STATE VENDOR OR MEDICAID NO.
(L2) **978740200**

3. NAME AND ADDRESS OF FACILITY
(L3) **HARMONY COMMUNITY HEALTHCARE INC**
(L4) **815 MAIN AVENUE SOUTH**
(L5) **HARMONY, MN** (L6) **55939**

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 **11/15/2013** (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 **43** (L18)

13.Total Certified Beds **43** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43			
(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 :
Robin Lewis, HFE NE II 01/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/22/2014 (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
04/01/1988
(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

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

CCN-245528

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. 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), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7708

December 5, 2013

Mr. Timothy Samuelson, Administrator
Harmony Community Healthcare Inc
815 Main Avenue South
Harmony, Minnesota 55939

RE: Project Number S5528024

Dear Mr. Samuelson:

On November 15, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506

Telephone: (507) 206-2731
Fax: (507) 206-2711

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 December 25, 2013, 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 December 25, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 15, 2014 (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 May 15, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245528	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY COMMUNITY HEALTHCARE INC	815 MAIN AVENUE SOUTH HARMONY, MN 55939

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 159 SS=C	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal	F 159	**F 159** The business office manager will send a quarterly statement of the resident funds to each resident or responsible party. The next quarterly statement will be sent December 31, 2013. The Resident funds policy has been revised to include the quarterly statement of the resident funds requirement to be sent to residents and/or responsible parties. The business office manager is responsible for sending out quarterly statements of the resident funds. Completion date: 12/20/2013	01/04/2014 SPN 12/20/13

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

Timothy Samuelson | Administrator | 12/19/13

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 159	Continued From page 1 funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide quarterly personal fund statements for 1 of 1 resident (R36) in the sample reviewed for personal funds. This had the potential to affect all 37 residents in the facility. Findings include: On 11/13/13, at 10:24 a.m. family (F)-1 member related to R36 stated they do not receive quarterly personal fund statements for R33. The Resident Personal Funds policy read, "4. Funds in excess of $100 will be accounted for with interest each quarter and a quarterly statement will be sent to the resident/responsible	F 159		

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F 159	Continued From page 2 party." On 11/13/13, at 1:10 p.m. the business office manager (BOM) verified the facility did not send out quarterly personal funds statements of balance in their accounts. The BOM stated the facility let family members know when accounts were approaching $10.00 left and stated families would call and ask how much money was in the accounts. The BOM stated she had not had families or residents request statements. The business office manager verified the facility policy was to provide quarterly statements to resident/responsible party if they had over 100.00 in the account. The BOM stated there were no residents in the facility that had $100.00 or more in their personal funds account. The BOM stated she was unaware the facility was to provide quarterly personal fund statements to all resident/ responsible parties that had a personal funds account.	F 159		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure it was a safe practice for 1 of 1 resident (R54) had been assessed to be safe to self-administer medication.	F 176	**F176:** The practice of self-administration of medication's was corrected for (R54) by coaching nurse on the dispensing of medications to residents who are not assessed to be capable of self-administration of medications. A Medication Self Administration Assessment was completed on R54. Nurse management team will review resident information to ensure that residents assessed as capable of medication self-administration have a notation in MATRIX medication orders under Administration Notes that says "May self-administer _____ after Nurse Setup" so it is printed on the Monthly Medication Administration Records.	

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F 176	Continued From page 3 Findings include: R54 self-administered two puffs of Symbicort (treatment of respiratory distress) inhalation independently but had not been assessed for safe self-administration of medication/s. R54 was admitted 11/12/13, with diagnosis that included dementia and chronic airway obstruction. Document review of physician orders dated 11/12/13, revealed orders for Symbicort aerosol inhaler 160-4.5 micrograms two puffs two times a day for chronic airway obstruction. Document review of the facility medication administration record for 11/13/13 and 11/14/13, revealed R54 received Symbicort inhalation as ordered. During observation of the medication pass on 11/14/13, at 8:45 a.m., licensed practical nurse (LPN)-A handed Symbicort canister to R54 who administered two puffs to self in rapid succession. Document review of facility Procedure Administering Medications policy dated 1/12, read, "Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. See Medication Self Administration Policy for further information." Document review of Medication Self Administration policy dated 1/12, read "Residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so safely." "1. If a resident requests to self administer medications an assessment must be done prior to	F 176	F176 Continued On December 19, 2013 the DON and Nurse Managers will meet with all licensed nursing staff and review resident self-administration guidelines and procedures; and watch a video on inhaler administration. An audit is being conducted to ensure a current Medication Administration Assessment has been completed for each resident. The audit will be completed and corrective action taken if needed by December 31, 2013. Nurse Managers will review open assessments weekly at rounds to ensure timely completion. Nurse Managers will complete a Medication Self Administration assessment during the Annual comprehensive assessment, or when a significant change is noted, for each resident. Management will do monthly medication pass observation for the first quarter and quarterly thereafter. A report to the QA Committee will be done for 4 quarters. COMPLETION DATE: ~~12/26/2013~~ → 12/25/13 ~~12/26/13~~ JPN JPN	

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F 176	Continued From page 4 authorization. As part of their evaluation, the nurse manager and practitioner will assess each resident ' s mental and physical abilities, to determine whether a resident is capable of self-administering medications. " During interview on 11/15/13, at 11:35 a.m., director of nursing verified the facility lacked an assessment to determine if R54 was safe to self-administer inhalation therapy.	F 176	**F274:** A significant change MDS was open and in progress for Resident (R29) when cited. The MDS was completed and signed on 11/27/13. The interdisciplinary team met on 11/18/13 and discussed each resident individually for potential significant change. Reviewed the residents currently on Hospice to ensure Significant Change MDS were completed. The Interdisciplinary team will continue to meet weekly. A new form was created for weekly rounds including a section for significant changes. This form will be used by Nurse Managers and shared with staff on a weekly basis. The Resident Assessment / MDS policy was reviewed and updated. COMPLETION DATE: 12/20/2013	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a significant change assessment for 1 of 1 resident (R29) reviewed for hospice. Findings include: R29 lacked a significant change assessment after admitted to hospice on	F 274		

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F 274	Continued From page 5 10/25/13 when R29 received an indwelling Foley catheter and did not previously have one and R26 had weight loss compared to the most resent Minimum Data Set (MDS). R29 was admitted to the facility 7/27/10. Diagnosis included Down's syndrome, dementia, anxiety, pneumonia, cough and chronic pain. The facility identified R29 on the quarterly Minimum Data Set (MDS), dated 9/6/13, to have short and long term memory problem, severely impaired decision making, behaviors present, no moods, totally dependent on two staff for activities of daily living, received scheduled pain medications, no as needed pain medications, at risk for pressure ulcers, no unhealed pressure ulcers, no catheter, no hospice and always incontinent of bowel and bladder. The facility identified R29 on the quarterly pain assessment dated 9/6/13, to have soft tissue pain, received scheduled pain medications, received no as needed pain medications, received non-pharmacological interventions for pain and indicators of pain included non-verbal sounds, facial and body movements. Document review of physician visit report assessment and plan dated 10/24/13, revealed hospice was appropriate for R29 related to past massive stroke, advanced dementia, intellectual disability, frequent respiratory infections and overall deterioration over past years. Document review of nursing progress notes dated 10/25/13 revealed R29 was admitted to hospice on 10/25/13, Foley catheter was placed and had immediate return of urine. Review of	F 274		

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F 274	Continued From page 6 registered dietician note dated 11/1/13, revealed R29 received pureed diet, intake sporadic from 10-100%, weights down 5.4% in past 3 months, received supplements three times a day, skin on buttocks intact, received Arginaid daily for skin integrity, decrease in weight and intake expected with progression of the disease. During interview on 11/14/13, at 11:25 a.m., registered nurse-B (RN-B) stated R29 was admitted to hospice on 10/25/13, Foley catheter was placed on 10/25/13, related to hospice felt the catheter would help with healing resident's sore bottom from loose stools and currently treated with antibiotics for urinary infection. RN-B verified the facility lacked conducting a significant change MDS assessment after admitted to hospice. Document review of facility Resident Assessment/MDS policy dated 4/13, directed staff #1. "The Nurse Manager is responsible for ensuring that the Care Team conduct timely resident assessments and reviews according to the following schedule: a. Within fourteen (14) days of the resident's admission to the facility; b. When there has been a significant change to the resident's condition; c. At least quarterly; and d. Once every twelve (12) months."	F 274		
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	F 315		

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F 315	Continued From page 7 resident's clinical condition demonstrates that 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 appropriate catheterization care was implemented for 2 of 3 residents (R29 & R36) and the facility failed to provide a medical justification for prophylactic antibiotic usage for 1 of 2 residents (R18) reviewed for catheter care. Findings include: R29 had indwelling urinary catheter, urinary infection and received catheter care in a manner to potentially cause infection. R29 was admitted to the facility 7/27/10. Diagnosis included urinary tract infection. The facility identified R29 on the quarterly Minimum Data Set (MDS), dated 9/6/13, to have short and long term memory problem, severely impaired decision making, totally dependent on two staff for activities of daily living, received scheduled pain medications, no as needed pain medications, at risk for pressure ulcers, no unhealed pressure ulcers, no catheter and always incontinent of bowel and bladder. Document review of nursing progress notes dated 10/25/13 revealed R29 was admitted to hospice on 10/25/13, Foley catheter was placed and had immediate return of urine. Document review of nursing progress notes dated 11/6/13,	F 315	**F315:** Posey urine bag holders were obtained for both R29 and R36, staff educated on correct use. When lying down R36 bed is in low position with safety mat as she is at High Risk for fall, staff instructed to put catheter and tubing in a pillow case on the mat next to the bed as the bag cannot be attached to the bed in low position. The bathroom in which R18 was using was cleaned immediately. Bladder assessment completed and physician note dated 11/19/13 states "Prophylaxis appears to be helping to decrease the frequency of R18s UTI's. He went 6 months infection free before developing a UTI in September, none since." UA were done on 9/19/13, 10/22/13, 11/18/13, 11/29/13, 12/13/13, and the only one that was positive for UTI was 9/19/13. Antibiotic was started on 10/23/13 physician note states "will start cipro empirically since he has a history of recurrent UTI."	

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F 315	Continued From page 8 revealed resident started antibiotic therapy for urinary tract infection. R29 ' s care plan dated 9/19/13, directed staff to: required total assist for activities of daily living, grooming, hygiene, dressing, transfers, toileting, bathing and mobility. Care plan dated 11/12/13, directed staff that R29 had indwelling Foley catheter. During observations on 11/12/13, at 5:20 p.m., R29 sat in wheelchair at dining room table with urinary catheter bag covered but laid on dining room floor and catheter tubing uncovered. During observations on 11/12/13, at 8:00 p.m., R29 was in same position with catheter bag on the floor and catheter tubing uncovered. During observations on 11/13/13, at 2:22 p.m., R29 sat in wheelchair in dining room with urinary catheter bag covered but laid on dining room floor. During observations on 11/14/13, at 8:05 a.m., nursing assistant (NA)-B and NA-C provided partial bath for R29. During cares, R29 was turned to the right side to expose coccyx, peri-rectal area and under abdominal fold skin red and excoriated. While on the right side, NA-C cleansed the peri-rectal area with a disposable cleansing wipe. NA-C was observed to wipe the catheter tubing from approximately two inches of tubing to the meatus and on to the rectal area. This was repeated three times with the same soiled disposable wipe. During interview at that time, NA-C verified they had cleansed the catheter tubing to the skin and then on to the rectal area and repeated with same	F 315	F315 continued Review will be completed by Nurse Managers of residents with indwelling / self-catheters to ensure bladder assessments are completed/up to date. Audit will be done to identify residents on prophylactic antibiotics. Procedure written and will be implemented for Urinary Catheter Care at the CNA meeting on December 19, 2013. At the CNA meeting the DON and Nurse Managers will discuss catheter care; watch videos on catheter peri-care; and hand washing/gloving. Housekeeping staff has been asked to clean R18 bathroom twice daily. Nurse Managers and Pharmacy Consultant have set up monthly meetings to discuss residents on prophylactic medications. A report to the QA Committee will be done for 4 quarters. COMPLETION DATE: ~~12/26/2013~~ 12/25/13 ndh	

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F 315	Continued From page 9 wipe. NA-C then used a clean disposable wipe and repeated the same process as before by wiping the tubing to the meatus, rectal area and repeated two times. During interview at that time, NA-B and NA-C stated they were expected to cleanse the catheter tubing from the meatus away from the body to prevent infection. During interview on 11/14/13, at 11:25 a.m., registered nurse-B (RN-B) verified the urinary tract infection was the first one R29 had this year. RN-B stated she expected catheter care to include cleansing from the meatus down the catheter tubing away from body and to use soap and water or with the disposable cleansing wipes. During interview on 11/14/13, at 1:15 p.m., NA-B and NA-C stated staff was expected to place the catheter bag into a cloth covering and position underneath the wheelchair and off the floor. They stated the catheter tubing was to be placed inside slacks and not visible. During interview on 11/15/13, at 11:30 a.m., director of nursing stated the facility lacked a policy for catheter care and placement of catheter bag. R36 had an indwelling urinary catheter and the catheter bag was not appropriately placed to prevent urinary tract infection/s. During observations on 11/14/13 at 6:52 a.m., 7:43 a.m., 8:51 a.m. and 10:03 a.m., R36 was noted to be sleeping in bed and the catheter bag was sitting directly on the floor mat. 6:52 p.m. sleeping in bed, catheter bag on the floor mat.	F 315		

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F 315	Continued From page 10 During an observation on 11/14/13 at 10:12 a.m. nursing assistants (NA)-A and NA-K were providing personal cares to R36. R36 was in the bed and the catheter bag was sitting on the floor mat. The floor mat was moved away from the side of the bed and the catheter bag was placed on the floor of the room. During an interview on 11/14/13 at 1:05 p.m., NA-K stated the catheter bag was often placed the floor mat in R36's room and not attached to the bed frame. NA-K verified the catheter bag should have been attached to R36's bed frame and not placed on the floor mat or the floor of R36's room. During an interview on 11/14/13 1:16 p.m., the director of nursing (DON) confirmed the catheter bags for residents should be hung on the bed frames and not placed on the floor mats or the floors of residents rooms. The DON also verified she expected the catheter bags to be covered with a cloth bag and not be touching the floor when residents were in wheelchairs in the common areas of the facility. R18 had not been assessed for bladder/catheter function, was on prophylactic antibiotic (Trimethoprim) and continued to have chronic urinary tract infections. R18 was admitted on 8/22/13, with diagnoses that included but not limited to stage III chronic kidney disease, neurogenic bladder and urinary tract infections. During review of the medical record it was noted R18 had a physician order for Trimethoprim (antibiotic) 100 milligrams (mg) one tablet at bedtime with a start date of 8/22/13. During review of R18's medical record revealed no bladder assessment had been completed.	F 315		

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	245528	A. BUILDING _____ B. WING _____	11/15/2013

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F 315	Continued From page 11 Further review of medical record revealed R18 had urinary tract infection on 9/19/13 and again on 10/22/13 while on the prophylactic medication. R18 had been seen by urology and nephrology with no documentation to evaluate the risk factors and support the continued use of prophylactic antibiotic therapy for R18. R18 ' s care plan dated 9/16/13; identified R18 required intermittent catheterizations related to benign prostate hypertrophy. R18 had been intermittent catheterizing self at home four times daily prior to admission to facility. Goal was for R18 to continue to be independent with intermittent catheterization. Approaches directed staff to provide set up assistance or supervision for catheter care and to provide necessary catheter supplies. Care plan had been revised to identify prophylactic antibiotic after interviews. During observation on 11/12/13, at 7:57 p.m. three catheters (two in each pack) were laying directly on the floor and one out of the package along with two boxes of catheters directly on the floor. Registered nurse (RN)-A verified catheters were on the bare bathroom floor and indicated R18 self-intermittent catheterizes but confirmed the catheters should not have been stored directly on the bathroom floor. The next day on 11/13/13, at 8:58 a.m. catheters still remained on the floor in packages plus the two boxes. During interview on 11/13/13, at 3:13 p.m. the director of nursing (DON) verified no bladder/catheter assessment had been completed for R18. The DON indicated the bladder assessment should have been done upon admission.	F 315		

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F 315	Continued From page 12 During interview on 11/13/13, at 3:40 p.m. registered nurse (RN)-C confirmed if someone comes in with a catheter and prophylactic antibiotic they would have had a bladder assessment completed upon admission. RN-C verified that R18 had not had a bladder assessment completed. During interview on 11/15/13, at 10:48 a.m. nursing assistant (NA)-K verified R18 catheterized self and revealed they had noticed the catheters on the floor in the bathroom. During interview on 11/15/13, at 10:50 a.m. R18 verified had bladder infections at home as well as at facility. R18 indicated kept getting urine tested and physician indicated they were going to keep resident on a small dose of antibiotic of some kind but confirmed was still getting the bladder infections. During interview on 11/15/13, at 9:28 a.m. the DON verified R18 was on prophylactic antibiotics and had continued to have two urinary tract infections while on prophylactic antibiotic since admission. The DON indicated they had not realized R18 was on prophylactic antibiotics but had known R18 had chronic urinary tract infections. During interview on 11/15/13, at 11:22 a.m. registered nurse (RN)-C indicated the catheters were to be kept in the night stand drawer or closet not on floor. RN-C said up until Tuesday R18 had been in room by self and the only one using bathroom. During interview on 11/15/13, at 11:23 a.m. the DON would expect the catheters not to be kept	F 315		

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F 315	Continued From page 13 on the floor of the bathroom, should be kept in drawers or closet. DON verified no prophylactic antibiotic policy was available or developed.	F 315	**F323:**	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure side rail use was assessed to be safe for 1 of 3 residents (R9) who currently utilized side. Findings include: R9 side rails exceeded the recommended spacing in zone 1 and zone 3 as recommended in the current U.S. Department of Health and Human Services Food and Drug Administration (FDA) guidelines for Bed System Dimensional and Assessment Guidance to Reduce Entrapment, issued 3-10-06. R9 had not been assessed by the facility to determine if she could safety use the bed rail. R9 had a diagnosis listed on the care plan dated 10-22-13 which included Cerebral Vascular Accident (CVA). The quarterly Minimum Data Set (MDS) dated 10-4-13 identified R9 had no cognitive impairment and needed extensive assistance of one for bed and transfer mobility. During observation on 11-12-13 at 2:30 p.m. R9 bed had a McKesson home bed with an assist	F 323	The side rail was removed from R9's bed. R9 is using a full sized bed brought from home; she is not using the hospital bed provided by facility. She was referred to Therapy for bed positioning. The Guidance for Industry and FDA Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, issued 3/10/2006, refers to Hospital Beds. At this time there are no other residents in this facility using personal beds brought from home. Currently R9 is the only resident with a personal bed brought from home. In the future residents requesting to bring their personal beds from home will be assessed by therapy for bed mobility and handled on a case by case basis. Located product - AbleRise Bed Assist that would meet standards and provide a safe option for future residents with beds brought from home. COMPLETION DATE: 12/20/2013	

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F 323	Continued From page 14 handle side rail located on the right side of the bed which was attached to the bed by a sliding bar placed between the mattress and the box spring but not secured to the bed frame. The width of the side rail was 19.75 inches long, 13.5 inches high, and was approximately a 4 inches gap between the mattress and the metal rail. The bed rail remained on the bed with the approximately 4 inch gap between the rail and mattress during observation on 11-13 at 2:00 p.m.; and again on 11-14 at 10:00 a.m. The gap had the potential for causing an entrapment of the neck or body between the rail and mattress and between the handle itself, as identified by the FDA guidelines for Bed System Dimensional and Assessment Guidance. During interview on 11-12-13 at 2:30 p.m. R9 stated she used the side rail to assist with turning and the facility had never spoken to her regarding any safety concerns regarding the spacing with the side rails. During interview on 11-13-13 at 10:40 a.m. Registered Nurse (RN)-C stated they had not completed any assessment of the side rail to determine if R9 was safe to use the rail despite having the large gap within the rail, and between the mattress and side rail for R9. RN-C verified the large gaps in the side rail and stated the side rail slides out from between the mattress and the bedspring which formed the gap between the mattress and the side rail. RN-C then pushed the side rail tight to the mattress to eliminate the gap. During interview on 11-13-13 at 3:49 p.m. R9's family member (FM)-K stated R9 is blind in her right eye and has severely poor vision in her left eye. Because of the poor vision, the " grab bar " is needed to assist R9 with bed mobility. FM-K stated the facility had not spoken to her regarding safety concerns with R9's side rail.	F 323		

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F 323	Continued From page 15 A facility policy entitled Bed Safety/Side Rails dated October 2012 read, "To try to prevent death/injuries from the beds and related equipment (including the frame, mattress, side rails, headboard, foot board, and bed accessories). The facility shall promote the following approaches: a. Annual inspection by maintenance of all beds and related equipment to identify risks, and problems including potential entrapment risks; b. Review that gaps within the bed system are within the dimensions established by the FDA [Food & Drug Agency] (Note: The review shall consider situations that could be caused by the resident's weight, movement or bed position); c. Ensure that when bed system components are worn and need to be replaced, components meet manufacturer specifications; d. Ensure that bed side rails are properly installed using the manufacturer's instructions and other pertinent safety guidance to ensure proper fit (e.g., avoid bowing, ensure proper distance from the headboard and footboard, etc.); e. Identify additional safety measures for residents who have been identified as having a higher than usual risk for injury including entrapment (e.g. altered mental status, restlessness, etc.)."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329		

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F 329	Continued From page 16 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to identify parameters for use of as needed (PRN) psychotropic medications, to document non-pharmacological interventions and if pain medication was effective for relieving pain for 1 of 5 residents (R1) reviewed for medication use. Findings include: R1 received PRN psychotropic medications however, there had not been specific parameters identified for use of the medications. Also there was no monitoring to determine if non-pharmacological interventions or if psychotropic or pain medications were effective for R1 R1 was admitted to the facility on 9/29/13 with diagnoses including: senile dementia, nonorganic psychosis, obsessive compulsive disorder and	F 329	**F329:** Heartland Hospice is currently writing parameters for use of PRN medications for R1, they will provide the parameters to the facility NLT 12/20/13. Until parameters are received staff is to call Hospice when in doubt of how to proceed with PRN Medications. The nurse managers will review all resident PRN medications and discontinue medications that have not been used within the last 90 days or are covered under standing orders. The nurse managers will update PRN administration sheets to include non-pharmacological approaches for both pain and psychotropic medications. Nursing Managers will review these approaches and proper documentation at the Nurses Meeting December 19, 2013. The hospice parameters will be used for all hospice residents. The Nurse Managers will check nurse compliance on a daily basis for the first week and then weekly for a month then monthly for the first quarter, and quarterly thereafter. COMPLETION DATE: ~~12/26/2013~~ 12/25/13 12/5/13	

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F 329	Continued From page 17 anxiety disorder. R1's current physician orders dated 10/3/13 included PRN orders for the following psychotropic medications: ABH gel (Ativan, Benadryl, Haldol) amount to administer 1 cc [cubic centimeter] q [every] 6 hours prn; topical prn- as needed. Haloperidol lactate concentrate; 2 mg [milligrams] /ml [milliliters]; amount to administer: 1 mg q 2 hours prn; oral prn. Lorazepam Intensol (lorazepam) - schedule IV concentrate; 2 mg/ml; amt [amount]: 1 mg q 6 hours prn. Morphine concentrate - Schedule II Solution; 100 mg/5ml (20mg/ml); amount to administer: 1 ml/20mg q 1 prn; oral prn. Review of the September, October and November 2013 medication administration record (MAR) showed the following: R1 received PRN Morphine 17 times in the month of September and the facility did not document the effectiveness of the medication 5 of the 17 times the medication was administered. R1 received PRN Morphine 10 times in the month of October and the facility did not document the effectiveness of the medication 8 out of the 10 times the medication was administered. R1 received PRN Morphine 1 time in the month of November 2013, and the facility did not document the effectiveness of the PRN the medication administered. In addition the facility failed to consistently document non-pharmacological interventions attempted prior to the PRN pain medication being administered for the months of September, October and November 2013. R1 received PRN Haldol 1 time in the month of	F 329		

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F 329	Continued From page 18 September 2013 and the facility did not document the effectiveness of the medication. R1 received PRN Ativan 4 times in the month of September and the facility did not document the effectiveness of the medication 2 of the 4 times the medication was administered. R1 received PRN Ativan 3 times in the month of October and the facility did not document the effectiveness of the medication 3 of the 3 times the medication was administered. In addition the facility failed to consistently document non-pharmacological interventions were attempted prior to the PRN Ativan being administered for the months of September and October 2013. During an interview on 11/15/13 at 11:37 a.m. licensed practical nurse (LPN)-B verified the PRN psychotropic medications for R1 did not provide parameters for use. LPN-B verified nursing was to attempt and document non-pharmacological interventions used prior to administering PRN pain and psychotropic medications. LPN-B verified Nursing was also to document the effectiveness of the PRN pain and psychotropic medications. LPN-B verified as evidenced by the MAR and progress notes nursing did not consistently document the effectiveness of the PRN medications or attempt and document non-pharmacological interventions used prior to administering PRN psychotropic and pain medications for R1. During an interview on 11/15/13 at 11:04 a.m., the director of nursing verified there were no parameters in place for the use of the PRN psychotropic medications for R1. The DON verified staff would need to use nursing judgment to determine which PRN medication to	F 329		

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F 329	Continued From page 19 administer. The DON stated she would clarify the PRN orders with hospice staff as they were hospice orders. The DON stated she expected staff to attempt non-pharmacological interventions prior to giving PRN pain or psychotropic medications. The DON stated documentation should be completed in the nurse progress notes of the non-pharmacological interventions tried and symptoms being displayed prior to administration of the PRN medication. The DON stated after the medication was given, the nurse needed to document the effectiveness of the medication in the MAR. The DON verified facility did not have documentation of non-pharmacological interventions or follow up for the effectiveness of the PRN medications on a consistent basis. Stated she would expect this documentation to be completed each time a PRN medication was given to a resident.	F 329		
F 371 SS=F	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 store dry food and thawed raw meat appropriately to prevent the	F 371		

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F 371	Continued From page 20 possibility of food borne illness. This had the potential to affect 37 of 37 residents who received food from the kitchen. Findings include: The facility failed to ensure raw and cooked meats were appropriately stored. During observation of the kitchen on 11/12/13 at 1:10 p.m. with the certified dietary manager (CDM) the following was observed: The walk in cooler contained a 4 pound package of cooked ham located next to a 5 pound package of raw hamburger thawing on a shallow tray. The edges of the raw hamburger were hanging over the rim of container, next to the cooked ham. This was pointed out to the CDM who removed the cooked ham and placed it on a shelf above the raw thawing hamburger. The same day 11/12/13 at 4:02 p.m. the walk in cooler was again observed. There was a cooked 4 pound ham and 5 pounds of cooked chicken sitting on the bottom shelf in the cooler. Directly above the cooked meats was the 5 pounds of raw ground beef sitting on a shallow tray. Cook-D was informed of this practice, and she removed the cooked meat from the bottom shelf and placed it above the raw hamburger. She stated I did not know that raw meat needed to be thawed on the bottom shelf, and not to place cooked meat below the raw product. A facility policy titled Food Storage dated 2013 indicated, "Cooked foods must be stored above raw foods to prevent contamination." FOOD IN DRY STORAGE HAD NOT BEEN DATED WHEN OPENED: During the tour of the dry storage area in the kitchen with the CDM on 11/12/13 at 1:15 p.m. the following was observed: A two pound box of quick oats was opened. There was no date of when the product was not	F 371	**F371** All open containers were dated and bagged immediately. Raw meat and cooked meat were immediately stored separate and properly. Certified Dietary Manager (CDM) will educate all dietary employees on the storage policy and guidelines for the walk in cooler regarding raw and cooked meat. The policy and guidelines will be posted in the walk-in cooler and the shelves will be labeled. CDM will educate all dietary employees on the storage and labeling policy and guidelines for dried goods that have been opened. All open packages will be labeled with the open date and placed in a zip seal bag. The CDM is responsible for proper storage and will monitor dry goods storage and walk-in cooler storage and will coach employees on proper storage when she finds improper storage. Completion date: ~~12/26/2013~~ 12/25/13 apn	

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F 371	Continued From page 21 opened, nor was it sealed in a food-grade plastic bag. The CDM stated the bags in the dry storage area should have been dated when opened. During interview on 11/14/13 at 1:00 p.m. Cook (C)-A stated she was not aware dry goods needed to be in a sealed food-grade plastic bag and stated, " We have been doing this [storing dry goods] for years." A facility policy titled Food Storage dated 2013 read. Plastic containers with tight-fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must be legible and accurately labeled. All opened bags and boxes will be labeled with the date opened and securely sealed."	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist identified parameters for use of as needed (PRN) psychotropic medications, failed to document	F 428	F428 Heartland Hospice is currently writing parameters for use of PRN medications for R1, they will provide the parameters to the facility NLT 12/20/13. Until parameters are received staff is to call Hospice when in doubt of how to proceed with PRN Medications. The nurse managers will review all resident PRN pain and psychotropic medications and discontinue medications that have not been used within the last 90 days or are covered under standing orders.	

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F 428	Continued From page 22 non-pharmacological interventions and effectiveness for PRN psychotropic and pain medications for 1 of 5 residents (R1) reviewed for unnecessary medications. Findings include: R1 received PRN psychotropic medications however, there had not parameters identified for use of the medications. Also there was no monitoring to determine if non-pharmacological interventions or if psychotropic or pain medications were effective for R1 R1 was admitted to the facility on 9/29/13 with diagnoses including: senile dementia, nonorganic psychosis, obsessive compulsive disorder and anxiety disorder. R1's current physician orders dated 10/3/13 included PRN orders for the following psychotropic medications: - " ABH gel; ativan, benadryl, haldol; amount to administer 1 cc [cubic centimeter] q [every] 6 hours prn; topical prn- as needed. " - " haloperidol lactate concentrate; 2 mg [milligrams] /ml [milliliters]; amount to administer: 1 mg q 2 hours prn; oral prn. " - " Lorazepam Intensol (lorazepam) - schedule IV concentrate; 2 mg/ml; amt [amount]: 1 mg q 6 hours prn. " - " morphine concentrate - Schedule II Solution; 100 mg/5 ml (20 mg/ml); amount to administer: 1 ml/20 mg q 1 prn; oral prn. " Review of the September, October and November 2013 medication administration record (MAR) showed the following: R1 received PRN Morphine 17 times in the month of September and the facility did not document	F 428	F 428 continued Nurse Managers met with Consultant Pharmacist on December 3, 2013 to discuss expectations regarding monitoring for drug regimen irregularities. Will meet again in January to review parameters set by Hospice, and then meet monthly thereafter to discuss his findings and follow up on previous month report. Pharmacy Consultant will ensure parameters are set and followed for any resident on multiple psychotropic PRN medications. Pharmacist consultant will provide a report to the QA committee quarterly. COMPLETION DATE: ~~12/26/2013~~ 12/25/13 JDN	

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F 428	Continued From page 23 the effectiveness of the PRN medication 5 of the 17 times the medication was administered. R1 received PRN Morphine 10 times in the month of October and the facility did not document the effectiveness of the PRN medication 8 out of the 10 times the medication was administered. R1 received PRN Morphine 1 time in the month of November and the facility did not document the effectiveness of the PRN the medication administered. In addition the facility failed to consistently document non-pharmacological interventions attempted prior to the PRN pain medication being administered for the months of September, October and November 2013. R1 received PRN Haldol 1 time in the month of September and the facility did not document the effectiveness of the medication. R1 received PRN Ativan 4 times in the month of September and the facility did not document the effectiveness of the medication 2 of the 4 times the medication was administered. R1 received PRN Ativan 3 times in the month of October and the facility did not document the effectiveness of the medication 3 of the 3 times the medication was administered. In addition the facility failed to consistently document non-pharmacological interventions were attempted prior to the PRN Ativan being administered for the months of September and October 2013. During an interview on 11/15/13 at 11:37 a.m. licensed practical nurse (LPN)-B verified the PRN psychotropic medications for R1 did not provide parameters for use. LPN-B verified nursing was to attempt and document non-pharmacological interventions used prior to administering PRN pain and psychotropic medications. LPN-B	F 428		

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F 428	Continued From page 24 verified Nursing was also to document the effectiveness of the PRN pain and psychotropic medications. LPN-B verified as evidenced by the MAR and progress notes nursing did not consistently document the effectiveness of the PRN medications or attempt and document non-pharmacological interventions used prior to administering PRN psychotropic and pain medications for R1. During an interview on 11/15/13 at 11:04 a.m., the director of nursing verified there were no parameters in place for the use of the PRN psychotropic medications for R1. The DON verified staff would need to use nursing judgment to determine which PRN medication to administer. The DON stated she would clarify the PRN orders with hospice staff as they were hospice orders. The DON stated she expected staff to attempt non-pharmacological interventions prior to giving PRN pain or psychotropic medications. The DON stated documentation should be completed in the nurse progress notes of the non-pharmacological interventions tried and symptoms being displayed prior to administration of the PRN medication. The DON stated after the medication was given, the nurse needed to document the effectiveness of the medication in the MAR. The DON verified facility did not have documentation of non-pharmacological interventions or follow up for the effectiveness of the PRN medications on a consistent basis. Stated she would expect this documentation to be completed each time a PRN medication was given to a resident. Review of the Consultant Pharmacist Service Agreement (MN) dated 8/6/13 read, " 5. Monthly reviews of the drug regimen of each patient with	F 428		

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F 428	Continued From page 25 written, dated and signed reports of any irregularities noted will be delivered to the Director of Nurses. The review shall include recommendations regarding aspects of drug administration, interactions, side effects, doses labs and the potential for unnecessary drugs as required by state, federal and other appropriate regulatory groups. " During an interview on 11/15/13 at 3:35 p.m. the consultant pharmacist verified PRN psychotropic medications required parameters for use. The consultant pharmacist stated he would expect the facility to attempt and document the effectiveness of non-pharmacological interventions used and to document the effectiveness for PRN psychotropic and pain medications administered to residents.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431	F431: Nurse immediately notified DON of concern with disposal of Fentanyl Patch. DON verified patch was in sharps container. Reviewed and updated Gundersen Harmony Care Center Nursing Policy/Procedure for Controlled Medications dated August 2013. New procedure for disposal of Fentanyl Patches will be discussed and put into place at the Nurses Meeting December 19, 2013. Patches will be kept in the locked narcotic drawer until shift change when two nurses will initial confirming disposal in the sharps container. COMPLETION DATE: 12/20/2013	

12/20/13

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F 431	Continued From page 26 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to dispose of used narcotic medication in a safe and secure manner for 1 of 1 resident (R1) who used fentanyl patches a narcotic medication. Findings include: R1 received fentanyl patch (a narcotic pain medication) removed without disposal witnessed by two staff. Document review of physician orders for R1 dated 6/7/13, revealed orders for fentanyl patch 100 microgram (mcg), two patches transdermal and change patch every 72 hours. Diagnosis for the fentanyl patch was encounter for palliative care. Document review of the facility medication administration record dated 10/1/13 to 10/31/13 and 11/1/13 to 11/14/13, revealed R1 received fentanyl patches as ordered.	F 431		

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F 431	Continued From page 27 During observations of the medication pass on 11/14/13, at 10:45 a.m., licensed practical nurse (LPN)-B removed two 100 mcg fentanyl patches from R1's left upper chest. LPN-B folded the patches several times until very small and placed into a small medication envelope. Observations revealed, after new fentanyl patches were applied, LPN-B placed the two used fentanyl patches in the small medication envelope into the medication cart sharps container. During interview on 11/14/13, at 2:15 p.m., LPN-B verified the two used fentanyl patches were disposed of in the medication cart sharps container and had not been witnessed by two nurses. During interview at that time, registered nurse-B (RN-B) verified the facility lacked a process for documentation of disposal of fentanyl patches. RN-B and LPN-B verified the facility lacked process to witness and sign for disposal of fentanyl patches. During interview on 11/14/13, at 2:20 p.m., director of nursing stated she expected staff to record destruction of fentanyl patches in the narcotic log book, according to facility policy. Director of nursing verified she did not expect two nurses to witness the destruction of fentanyl patches. Document review of facility Controlled Medications policy dated 8/13 revealed #12. "When controlled medication is discontinued for any reason the following procedure will be followed: c. Two Nurse signatures required; e. Director of Nursing and Pharmacist will destroy on a monthly basis, " and #13. placement and removal of Fentanyl Patches: " e. When	F 431		

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F 431	Continued From page 28 removed the patch shall be folded in half and put into the sharps container. Mark the patch destroyed in the Narcotic Record Book (In from Pharm [pharmacy] column)." During telephone interview on 11/15/13, at 3:35 p.m., the consultant pharmacist stated the facility should have a witness to the placement of fentanyl patch into the sharps container, to help prevent diversion. He stated fentanyl patches should be treated like any other narcotic.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	F441: Immediately upon notification of the infection control issue a note was written in the communication book to remind staff to change gloves after each resident contact and cleanse hands in between gloves. On December 19, 2013, the nursing staff will meet and discuss Infection Control policies and watch videos on peri-care; eye drop administration (nurses); and hand washing/gloving. EduCare training module "Infection Prevention & Control" has been assigned to all nursing staff and is to be completed by December 31, 2013. The glove use policy will be reviewed and updated by December 31, 2013. Infection control committee will meet monthly to review the remainder of the Infection Control policies. Infection reports are presented at QA on a quarterly basis. COMPLETION DATE: ~~12/26/2013~~ 12/25/13	

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F 441	Continued From page 29 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to prevent the spread of infection by ensuring proper glove removal was implemented during assistance with activities of daily living for 1 of 1 resident (R42) observed during activities of daily living (ADL) care and for 1 of 1 resident (R18) who had eye drops instilled without using a procedure to prevent the spread of eye infections. Findings include: R42 had cares done by Nursing assistant (NA)-A who had cleansed R42 during perineal care with a washcloth, failed to remove the soiled gloves prior to completion of personal cares and handling of common-use resident equipment. During observation on 11/4/13, at 8:04 a.m. R42 was assisted using stand lift and NA-A to a standing position. NA-A with gloved hands cleansed the front of the peri-area and continued to cleanse the buttocks/rectal area while R42 remained suspended in a half seated position attached to the sit to stand machine. NA-A	F 441		

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F 441	Continued From page 30 continued to pull up clean incontinent product and sweat pants without changing the soiled gloves. NA-A with same soiled gloves transferred R42 using the sit to stand machine with both hands holding on to sit to stand handles and button controller, released sling from around resident waist, placed pillow behind resident, proceeded to remove soiled gloves. During interview on 11/14/13, at 8:31 a.m. NA-A stated, "I should have removed my gloves after the pericare." NA-A verified had continued with the transfer without changing gloves. During interview on 11/14/13, at 11:12 a.m. the director of nursing (DON) indicated would expect staff to remove gloves after perineal care and hand sanitize and place new gloves on to continue with cares. During interview on 11/15/13, at 10:06 a.m. registered nurse (RN)-C indicated would expect staff to change the gloves after perineal care before proceeding with cares. RN-C identified a Safety Fair in-service was held on 9/26/13. During the in-service staff gave demonstration regarding glove usage. RN-C also indicated verbal discussions had been held regarding changing gloves after contact with bodily fluids. It is the expectation that new gloves would be applied before proceeding with next procedure. R18 had received eye drops and they were not administered in a manner to prevent infection. R18 was observed during a medication pass on 11-12-13 at 7:25 p.m. by registered nurse (RN)-A. RN-A applied gloves and administered Brimonidine (treat glaucoma) 0.2 percent eye drops into both eyes of R18. Without changing her soiled gloves or washing her hands, RN-A	F 441		

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F 441	Continued From page 31 administered an insulin injection to R18 abdomen area. Then without changing her gloves or washing her hands, she administered a second set of eye drop medication Dorzolamide Tinolol (treat glaucoma) one drop into the left eye. During interview on 11-12-13 at 5:10 p.m. RN-A verified she did not change gloves between the first set of eye drops, the insulin injection, or the second eye drop medication. RN-A stated she should have changed her gloves between the first eye drop instillation, the giving of the insulin injections and before giving the second eye medication drops.	F 441	**F465:** Maintenance will develop a schedule for wall repair and room painting to include rooms 103, 120 and 121.	
F 465 SS=B	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 and interview, the facility failed to ensure an environment was maintained clean and in good state of repair for 21 of 27 resident rooms reviewed. Findings include: An environmental tour was conducted with the director of nursing and maintenance supervisor 11/15/13, at 10:00 a.m. Room 103 Missing paint on room walls. Room 106	F 465	Maintenance will hire a painter to pain door frames to bathrooms and corridor which will include rooms 106, 110, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 133, 134, 135, 136 and 137. All vents in resident room toilets will be removed, cleaned, painted and reinstalled. This will include rooms 120 122, 125, 129, 130, 131, 133, 134, 135, 136 and 137. Room doors, bathroom doors and closet doors will be assessed for repair with a cover over chips and cracks in the doors. This will include rooms 106, 120, 121, 123, 124, 125, 126, 127, 128, 130, and 137.	

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F 465	Continued From page 32 Chipped paint on the bathroom door frame, chipped wood on bathroom door, and debris on floor behind room door. Room 109 Bathroom toilet riser was duct taped to the toilet stool and not a cleanable surface. Room 110 Room door frame chipped paint. Room 120 Shared bathroom ceiling vent coated with thick dust, chipped paint on bathroom door frame from floor to 11 inch up on door casing exposing metal, loose bathroom wallpaper at door frame, dark brown stain around base of toilet, room heat register metal with scratches and missing paint, wall by room window with long cracks in the plaster, and bathroom door with chipped wood. Room 121 Bathroom door frame chipped paint, bathroom door chipped wood and bathroom wall paper peeled loose around the door frame. Room 122 Shared bathroom ceiling vent coated with thick dust , bathroom door frame chipped paint, four strips of anti-slip material on the floor by resident ' s bed and on the bathroom floor which were peeling and a non-cleanable surface, night stand wood finish worn and bare wood exposed. Room 123 Shared bathroom door frame chipped paint, chipped wood on room closet doors, chipped wood on bathroom door, and anti-slip strips on floor by the bed were peeling and a	F 465	F465 continued All rooms are scheduled for deep cleaning of floors in rooms and toilets. This will include room 120, 124, 125, 126 Base board will be replaced in room 124 and 126 In room 109, the toilet riser duct taped to the seat will be removed and replaced with a toilet riser that locks to the toilet seat. The wall paper will be removed in room 120 and 121 toilet and the walls will be repaired and painted. The non-skid floor strips in room and toilet of room 122 have been removed and the floor cleaned. The non-skid floor strips have been replaced in room 123.	

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F 465	Continued From page 33 non-cleanable surface. Room 124 Chipped paint bathroom door frame, missing piece of baseboard in main room, chipped wood on closet door, and cracks on floor by closet door. Room 125 Chipped paint bathroom door frame, chipped wood on closet door approximate two inch area, floor discolored under closet door, discolored floor areas in resident room and bathroom, taped area on the floor had an area missing around the edge, bathroom ceiling vent coated with thick dust. Room 126 Chipped paint bathroom door frame, missing part of baseboard in main room, chipped wood on closet door and cracks on floor by closet door. Room 127 Chipped paint bathroom door frame, floor underneath the sink discolored and with debris, lime build up around sink faucets, green tarnish on stool metal pipe, lime build up around stool metal pipe, cracks in floor, wood missing on bottom edge of closet door, strong foul urine odor in bathroom, bathroom ceiling vent coated with thick dust, and main room door with chipped wood. Room 128 Chipped paint bathroom door frame and chipped wood on closet doors. Room 129 Chipped paint bathroom door frame, bathroom ceiling vent coated with thick dust.	F 465	F 465 continued In room 135 the wall paper on the sink wall will be removed; the wall repaired and paint the entire room. The tile under the sink will be replaced. In room 137 the plaster above the room window will be repaired and the room will be painted. Redecorating of the corridors including the Memory Lane outside room 137 is being planned. The night stand in room 122 was the property of the resident and has been removed. Room 127 toilet fixtures will be cleaned and lime removed. The toilet no longer has a strong urine odor. Ceiling fixtures on Memory Lane, Golden Wheat Way and Country Lane have all been cleaned.	

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F 465	Continued From page 34 Room 130 Chipped paint bathroom door frame, bathroom ceiling vent with thick dust, bathroom and room door chipped wood. Room 131 Chipped paint bathroom door frame, bathroom ceiling vent with thick dust. Room 133 Chipped paint bathroom door frame, bathroom ceiling vent with thick dust. Room 134 Chipped paint bathroom door frame, bathroom ceiling vent with thick dust. Room 135 Chipped paint bathroom door frame, bathroom ceiling vent with thick dust, wall under room sink chipped paint and loose plaster, loose baseboard under room sink, main room door with chipped wood. Room 136 Chipped paint bathroom door frame, bathroom ceiling vent with thick dust. Room 137 Chipped paint bathroom door frame, bathroom ceiling vent with thick dust, cracked plaster above room window, large area of missing wall paper on wall outside of room 137 door. Observations of the following hallway ceiling light fixtures with debris: 5 of 6 hallway ceiling light fixtures on memory	F 465	F 465 continued Maintenance Director will be responsible for completion of this list. Administrator and Maintenance Director have done a walk through and completed a comprehensive repair list for all areas. That will be reviewed twice a year. The Corporate Compliance Committee will monitor progress. Completion date: ~~12/26/13~~ 12/25/13 JDN	

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	245528	A. BUILDING _____ B. WING _____	11/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY COMMUNITY HEALTHCARE INC	815 MAIN AVENUE SOUTH HARMONY, MN 55939

(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 465	Continued From page 35 lane, 6 of 7 hallway ceiling light fixtures on golden wheat way and 2 of 8 hallway ceiling light fixtures on country lane. During interview on the tour, maintenance supervisor stated housekeeping was responsible to clean the bathroom vents. Maintenance supervisor stated he inspected resident rooms weekly for repairs; staff notified him when repairs were needed, and the safety committee inspected rooms every two months for needed repairs. He stated he painted resident rooms as they became empty and that he had already painted five rooms. He also was responsible to clean light fixtures. During interview on tour, director of nursing and maintenance supervisor verified the findings. Document review of facility Bathroom Ventilation Systems policy dated 1/13/04, revealed Cleaning Schedule, " Vents shall be cleaned annually by the maintenance staff or if system is found to be in need of cleaning prior to the regular cleaning schedule." "All staff shall be instructed to look for build up of dust, lint or other foreign materials on the louvers during their daily cleaning of bathrooms. If housekeeping feels that there is an excess of dust built up they should contact maintenance staff. Maintenance staff shall check out vent in questions a clean per cleaning procedure."	F 465		

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	245528	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**11/13/2013**

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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 ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Harmony Healthcare 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 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POCok TS 12-19-13 Date received is 12/17 ok MW ML RECEIVED DEC 17 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 11-15-13 Dc: 12-35-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Timothy Samuelson — TITLE: Administrator — (X6) DATE: 12/20/13

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Harmony Healthcare is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1964, addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The facility is fully fire sprinklered. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 43 beds and had a census of 38 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
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 documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 38 residents. Findings include: On facility tour between 8:30 AM and 11:30 AM on 11/13/2013, the review of the fire drills reports for November 2012 to October 2013 and the following drills were missed: 1. 2012 4th quarter night shift 2. 2013 3rd quarter night shift This deficient practice was confirmed by the facility Maintenance Director (IK) at the time of	K 050	**K 050** Maintenance Director has established a yearly calendar with all fire drills planned for the 4th quarter 2013 and the year 2014. The plan assures a drill every shift each quarter Person Responsible: Maintenance Director Date Completed: 12/20/2013	

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K 050	Continued From page 3 discovery.	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, the facility failed to 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, Section 7-3.2. The deficient practice could affect all 38 residents. Findings include: On facility tour between 8:30 AM and 11:30 AM on 11/13/2013, the review of the available fire alarm annual testing/inspection documentation for the past 12 months revealed, that the facility failed to insure the fire alarm annual testing/inspection was done in a 12 month period. The 2012 testing/inspection was completed on 01/12/2012 and the 2013 testing/inspection was completed on 06/11/2013.	K 052	**K052** Maintenance Director has established a yearly calendar with all fire alarm tests planned for the year 2014. The calendar assures contact with the fire alarm test vendor to schedule the fire alarm test within 12 months of the previous test. Person Responsible: Maintenance Director Date Completed: 12/20/2013	

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K 052	Continued From page 4 This deficient practice was confirmed by the facility Maintenance Director (IK) at the time of discovery.	K 052		
K 069 SS=F	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, the facility's kitchen cooking hood fire extinguishing system was not maintained in accordance with 2000 NFPA 101 - 9.2.3 and 1998 NFPA 96 section 8.2. This deficient practice could affect all 38 residents. Findings include: On facility tour between 8:30 AM and 11:30 AM on 11/13/2013, the review of the kitchen hood system inspection documentation for the past 12 months revealed that the kitchen hood was not inspected every 6 months. The documented inspections were done on 10/25/12 and 06/06/13. This deficient practice was confirmed by the facility Maintenance Director (IK) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 069	**K069** The facility's kitchen hood fire extinguisher system was tested on 12/06/2013. Maintenance Director has established a yearly calendar with all fire alarm tests planned for the year 2014. The calendar assures contact with the kitchen hood extinguisher system test vendor to test the kitchen hood within the semi-annual 6 month period in 2014. Person responsible: Maintenance Director Date completed: 12/20/2013	