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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3E3S

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00887

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245496**

2.STATE VENDOR OR MEDICAID NO.
(L2) **611042800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MINNEOTA MANOR HEALTH CARE CENTER**
(L4) **700 NORTH MONROE STREET**
(L5) **MINNEOTA, MN** (L6) **56264**

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) **01/01/2014**

6. DATE OF SURVEY **09/16/2021** (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)
06/30

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Dawn Huelsman, HFE NE II 11/04/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/19/2021 (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
09/01/1987
(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.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
October 10, 2021

Administrator
Minneota Manor Health Care Center
700 North Monroe Street
Minneota, MN 56264

RE: CCN: 245496
Cycle Start Date: September 16, 2021

Dear Administrator:

On September 16, 2021, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 16, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by March 16, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Electronically delivered
November 24, 2021

Administrator
Minneota Manor Health Care Center
700 North Monroe Street
Minneota, MN 56264

RE: CCN: 245496
Cycle Start Date: September 16, 2021

Dear Administrator:

On October 10, 2021, we informed you that we may impose enforcement remedies.

Compliance with the Life Safety Code (LSC) deficiencies cited on September 16, 2021 has not yet been verified.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective September 16, 2021. (42 CFR 488.417 (b))

The CMS Region V Office will notify your Medicare Adminstrative Contractor (MAC) that the denial of payment for new admissions is effective September 16, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 16, 2021. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Minneota Manor Health Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 16, 2021. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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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:

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Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245496	A. BUILDING _____ B. WING _____	C 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINNEOTA MANOR HEALTH CARE CENTER	**700 NORTH MONROE STREET MINNEOTA, MN 56264**

(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
E 000	Initial Comments On 9/13/21 through 9/16/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 9/13/21 through 9/16/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5496016C (MN63320), H5496017C (MN73622), H5496018C (MN73624), H5496019C (MN73625), H5496020C (MN73626), H5496021C (MN73627), and H5496022C (MN73764), however NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaint was found to be UNSUBSTANTIATED: H5496015C (MN54771). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required	F 000		

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

Electronically Signed | 10/20/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the	F 578		10/27/21

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F 578	Continued From page 2 time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure appropriately signed physician orders for advanced directives (AD) for 5 of 23 residents (R1, R5, R8, R9, and R20). Findings include: R1's 5/26/21, quarterly Minimum Data Set (MDS) assessment identified R1's cognition was intact. R1's 7/6/21, physician orders failed to include advance directive (AD) orders or physician ordered life-sustaining treatment (POLST). R1's current, undated care plan identified her code status as Full Code. R1's 8/21/20, Cardio Pulmonary Resuscitation (CPR) Consent form was signed by R1 and witnessed by facility registered nurse (RN), but did not contain a physician (MD) signature. Current MD orders also contained no information on AD/CPR status. R5's 6/28/21, annual MDS identified R5 had	F 578	F578 1. R1 □ request for signed physician orders for advanced directives faxed 10-26-21 R5 - request for signed physician orders for advanced directives faxed 10-26-21 R8 □ Resident discharged from facility 10-21-21 R9 - request for signed physician orders for advanced directives faxed 10-26-21 R20 - request for signed physician orders for advanced directives faxed 10-26-21 2. 11 remaining residents charts will be reviewed for a signed physician order for advanced directive □ any resident that does not have a signed order: request for signed physician orders for advanced directives will be faxed 10-26-21 3. At any time the resident requests to change their advanced directive, the Care Coordinator will fax a new request for a signed physician order. 4. Care Coordinator will report any resident changes in their advance	

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F 578	Continued From page 3 moderate cognitive impairment. R5's physician (MD) progress notes and physician orders identified on 3/22/21, R5's Medicare 60 day physician's note failed to include AD orders or a Physician Ordered Life-Sustaining Treatment (POLST) order. Neither virtual or in-person provider visits after this date contained an order or provider signature authorizing AD. R5's current, undated care plan identified her code status as Do Not Resuscitate (DNR). R5's 7/15/21, Cardio Pulmonary Resuscitation (CPR) consent form identified it contained signatures of 2 family members and was witnessed by 2 RN's. The form failed to contain an MD signature. R8's 7/9/2, quarterly MDS identified R8 had intact cognition. R8's MD progress notes and physician orders identified no signed MD order for AD and/ or any code status. R8's 8/21/12, CPR consent form identified the form was signed by R8 and 2 RN's. There was no signature from the MD identifying they were made aware or agreed with R8's code status of DNR. R9's 7/12/21, quarterly MDS identified his cognition was intact. R9's current, undated care plan identified his resuscitation status as Full Code. R9's 4/6/21 CPR Consent form contained R9's signature, but no witness signatures had been	F 578	directive to the D.O.N. who will monitor and double check that the physician order request has been sent. Weekly 10/26/21 until closure 12/3/2021.	

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F 578	Continued From page 4	F 578		

included on the document.

R9's MD progress notes and physician orders identified on 9/14/21, during a virtual provider visit, there was no mention of the AD and/or CPR status having been ordered and signed by the MD

R20's 8/11/21, Significant Change MDS identified R20 had severe cognitive impairment.

R20's current, undated care plan identified his resuscitation status as DNR.

R20's 6/11/21, CPR Consent form identified No CPR and was signed only by a family member and a staff RN. No MD signature was acquired.

R20's MD progress notes and physician orders identified on 8/13/21, during a virtual provider visit, there was no mention of the AD and/or CPR status having been ordered and signed by the MD.

Interview on 9/14/21 at 2:35 p.m., with the medical director identified he expected the DNR/DNI and code status for each resident to be included in the list of orders and treatments reviewed and signed by the MD at the time of admission to the facility and renewed with scheduled provider visits. If there was a change in the resident's advance directive choice then he would expect the MD to be notified and signed MD orders obtained as soon as possible.

Interview on 9/15/21 at 4:06 p.m. with RN-A identified the facility process for completion of the CPR Consent form was explanation of what CPR, and DNR/DNI meant to the resident, question the resident and/or their representative of code status

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MINNEOTA MANOR HEALTH CARE CENTER	**700 NORTH MONROE STREET MINNEOTA, MN 56264**

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F 578	Continued From page 5 preference. Once the choice was made, the CPR consent form was completed, signed by the resident/family member and witnessed by the staff nurse who reviewed the information. The nurse would then enter the resident choice into the electronic medical record under the section for AD. This was competed by checking the appropriate box, which was saved on the system and populated the top of resident documents with the identification information along with the chosen code status. RN-A identified according to facility policy, an MD order was not required as it was felt to be a resident and/or family choice. Interview on 9/16/21 at 8:30 a.m., the director of nursing (DON) identified the facility did not routinely request signed MD orders for code status. At times the provider would occasionally note the AD and include it in the signed progress note or orders, but it was not consistently included. A policy related to AD was requested but not provided by the end of the survey.	F 578		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		10/27/21

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	245496	A. BUILDING _____ B. WING _____	C 09/16/2021

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F 656	Continued From page 6 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to ensure a comprehensive care plan was developed for psychoactive medication use that included target behaviors and individualized interventions for 2 of 5 residents (R1 and R17). Findings include:	F 656	F656 1. R1 □ Comprehensive care plan will be updated to include target behaviors and individualized interventions. Care plan update 10-26-21. Resident discharging on 10-27-21. R17 □ discharged from facility 10-19-21	

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F 656	Continued From page 7 R1's undated, Resident Face Sheet, identified R1 had been admitted to the facility originally in August 2020, with the the most recent re-admission in January 2021. R1 had a diagnosis of depression and anxiety. R1's 5/26/21, quarterly Minimum Data Set (MDS) assessment identified R1's cognition was intact. In the assessment, R1 was identified as feeling bad about themselves, felt they were a failure, or have let themselves or their family down for 2-6 days during the look-back period. R1 had trouble concentrating on things, such as reading the newspaper or watching television for 2-6 day during the look-back period. R1 needed total assistance for transfers, dressing, and locomotion, was always incontinent of bladder and bowel, took insulin, anti-anxiety, anti-depression, and diuretic (fluid pills) medication daily. R1's 7/6/21, physician orders identified R1 was to be administered buspirone (anti-depressant) 15 milligrams (mg) twice a day for anxiety disorder, starting 1/5/21, and paroxetine HCl 20 mg once each evening for anxiety disorder, starting 1/23/21. There were no identified anxiety symptoms R1 was diagnosed with, associated with those medicaion orders. R1's 8/13/21, care plan identified R1 was still unfamiliar with their nursing home routine, and continued to adjust to facility since September 2020. Staff were to allow R1 individual choices in their daily routine, assist R1 in quickly resolving any problems that arose, and gently help R1 be realistic in goal setting. R1 was at risk for injury related to psychotropic medication and was to be	F 656	2. 14 remaining residents care plans will be reviewed to ensure a comprehensive care plan is developed for psychoactive medication use that include target behaviors and individualized interventions. Care Plans will be updated 10-26-21. 3. Facility will monitor any changes residents have regarding psychoactive medications and update the care plans to ensure target behaviors and individualized interventions are in place. Care Coordinator will review weekly to ensure the care plan is updated and documentation is complete. 4. Weekly report will be reviewed with D.O.N. to ensure compliance. 10/26/21 until closure 12/3/21.	

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F 656	Continued From page 8	F 656		

be free of significant side effects for 90 days. Interventions were discussed with R1 and family. R1's family felt there was benefit to taking their medication and agreed to on-going use and have signed the informed consent. R1 was to take medications as ordered by physician. The pharmacy consult was to achieve the lowest dose necessary and would recommend trial reductions as deemed appropriate. Staff were to watch for and report side effects. Periodically staff were to perform a review of (targeted) behaviors to ensure R1 was receiving the appropriate dose. There was no mention what the target behaviors were, when they would be reviewed, or how the facility would determine if medication was appropriate or therapeutic.

Interview on 9/15/21 at 10:09 a.m., with trained medication aide (TMA)-A identified she was unaware of any specific symptoms or behaviors staff were to watch for. She revealed R1 had no behaviors but would tend to "worry a lot".

Interview on 9/15/21 at 2:37 p.m., with R1 identified she took anti-anxiety medication as she had a lot of anxiety and a little OCD (obsessive compulsive disorder). She liked things "a certain way". She said she liked to be in control and if that did not happen she would become very anxious. She felt the medication she took helped her with her anxiety.

R17's undated, Resident Face Sheet identified R17 had been admitted to the facility in February 2020 with a re-admission in January 2021. R17 had a diagnosis of depression.

R17's 8/6/21, quarterly Minimum Data Set (MDS) assessment identified R17's cognition was intact.

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F 656	Continued From page 9	F 656		

R17 had trouble falling asleep, staying asleep, and/or sleeping too much. R17 had poor appetite or would overeat 2-6 days during the look-back period. R17 took anti-depressant medication.

R17's 5/17/21, care plan identified staff were to allow resident individual choices in daily routine and where she wanted to spend her day. Staff were assist R17 to quickly resolve any problems, and encourage involvement with other residents and activities. Staff were to gently assist R17 be realistic in goal-setting. R17 was at risk for injury related to psychotropic medication and was to be be free of significant side effects for 90 days. Interventions were discussed with R17 and family. R17's family felt there was benefit to taking their medication and agreed to on-going use and have signed the informed consent. R1 was to take medications as ordered by the physician. The pharmacy consult was to achieve the lowest dose necessary and would recommend trial reductions as deemed appropriate. Staff were to watch for and report side effects. Periodically staff were to perform a review of (targeted) behaviors to ensure R17 was receiving the appropriate dose. There was no mention what the target behaviors were, when they would be reviewed, or how the facility would determine if medication was appropriate or therapeutic.

R17's 7/30/21, Physician Order Report identified citalopram 5 mg once a day for major depressive disorder, which was started on 6/11/21. There were no identified depressive symptoms R1 was diagnosed with, associated with those medicaion orders.

Interview on 9/15/21 at 9:10 a.m., with R17

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F 656	Continued From page 10	F 656		

identified she had been feeling down and depressed when she first moved to the facility but that had gotten better so she felt the medicaion "must be helping".

Interview on 9/15/21 at 10:10 a.m., with TMA-A identified R17 was independent and she was unaware of any symptoms staff were to watch for and report related to her depression. She stated R17 loved to visit and liked to go to activities.

Interview on 9/16/21 at 9:35 a.m., with registered nurse (RN)-B identified residents who receive psychoactive medication were to have targeted behaviors identified on the medication administration record (MAR). The nurse would document any behaviors in the residents progress notes. RN-B confirmed neither R1 nor R17 had identified target behaviors listed on the MAR or included on their care plans. RN-B agreed it would be hard to determine if a psychotropic medication would be therapeutic if there were no identified target behaviors to monitor for improvement.

Interview on 9/16/21 at 2:45 p.m., with the director of nursing (DON) identified the facility should be identifying target behaviors on the care plan for any resident receiving a psychotropic medication. She further, identified that the medication should be monitored for side effects. She revealed that the target behaviors should be charted on to know if there had been improvement or not with use of the medication. The DON confirmed her expectation would be a resident receiving a psychotropic medication would have identified target behaviors for the medication use and an individualized care plan with interventions for those target behaviors.

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F 656	Continued From page 11 Review of 9/16/21, Psychotropic Medication on Admit policy identified the facility was to review all anti-anxiety, hypnotic, and anti-psychotic medication with the resident's physician and work to achieve the lowest dose needed for the resident's well-being. The registered nurse case manager would obtain information about the medication and why it was started. The facility would then communicate with the provider about trial reductions and/or on-going use of the medication. The facility further, would monitor for side effects of medication.	F 656		

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245496	**MINNEOTA MANOR HEALTH CARE CENTER**	*K4 **09/16/2021**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 1

NUMBER OF THIS BUILDING 01

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2012 EXISTING
13	2786 R	2012 NEW

ASC Form		
14	2786 U	2012 EXISTING
15	2786 U	2012 NEW

ICF/MR Form		
16	2786 V, W, X	2012 EXISTING
17	2786 V, W, X	2012 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K321 or K351 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K321: [3] K351: [3]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1	A2	A3	A4	A5
[ ]	[X]	[ ]	[ ]	[ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A.	B.	C.
[X]	[ ]	[ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY