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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: NC8P

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY** — Facility ID: 00477

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245537**

2.STATE VENDOR OR MEDICAID NO.
(L2) **328542100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MINNEWASKA COMMUNITY HEALTH SERVICES**
(L4) **605 MAIN STREET, PO BOX 40**
(L5) **STARBUCK, MN** (L6) **56381**

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 **01/13/2019** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

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

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

12.Total Facility Beds **41** (L18)
13.Total Certified Beds **41** (L17)

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

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

* Code: **A 8** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 41 | | | |
| (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 :
Gail Anderson, Unit Supervisor — 01/15/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Enforcement Specialist — 01/15/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
**07/27/1989**
(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
**01/11/2019**
(L33)

DETERMINATION APPROVAL

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

CCN: 245537

The facility's request for a continuing waiver of the following health deficiency has been forwarded to the CMS Region V Office for its determination:

F-912 42 CFR 483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT.

Approval of the waiver request has been recommended.

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
CMS Certification Number (CCN): 245537

January 15, 2019

Administrator
Minnewaska Community Health Services
605 Main Street, PO Box 40
Starbuck, MN 56381

Dear Administrator:

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 28, 2018 the above facility is certified for:

41 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 41 skilled nursing facility beds.

Your request for waiver of F 912 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
January 15, 2019

Administrator
Minnewaska Community Health Services
605 Main Street, Po Box 40
Starbuck, MN 56381

RE: Project Number S5537031

Dear Administrator:

On January 13, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 4, 2019 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 standard survey, completed on November 29, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 28, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 29, 2018, effective December 28, 2018 and therefore remedies outlined in our letter to you dated December 13, 2018, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under F 0912 at the time of the November 29, 2018 standard survey has been forwarded to CMS for their review and determination.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: NC8P

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00477

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(L1) **245537**

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(L3) **MINNEWASKA COMMUNITY HEALTH SERVICES**
(L4) **605 MAIN STREET, PO BOX 40**
(L5) **STARBUCK, MN** (L6) **56381**

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 **11/29/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

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

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

12.Total Facility Beds **41** (L18)
13.Total Certified Beds **41** (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 |
|---|---|---|---|---|
| | 41 | | | |
| (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 :
Susan Bachleitner, HFE - NE II 12/26/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/10/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
**07/27/1989**
(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

Electronically delivered
December 13, 2018

Administrator
Minnewaska Community Health Services
605 Main Street, Po Box 40
Starbuck, MN 56381

RE: Project Number S5537031

Dear Administrator:

On November 29, 2018, 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 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.

## OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is January 8, 2019.

## ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (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 a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

## 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 March 1, 2019 (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 May 29, 2019 (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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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 |
|---|---|---|---|
| | 245537 | A. BUILDING _____ B. WING _____ | 11/29/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MINNEWASKA COMMUNITY HEALTH SERVICES | 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381 |

| (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<br><br>A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 11/26/18 through 11/29/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On 11/26/18 through 11/29/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 582 SS=D | Medicaid/Medicare Coverage/Liability Notice<br>CFR(s): 483.10(g)(17)(18)(i)-(v)<br><br>§483.10(g)(17) The facility must--<br>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-<br>(A) The items and services that are included in | F 582 | | 12/7/18 |

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

Electronically Signed | 12/20/2018

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245537 | A. BUILDING _____ B. WING _____ | 11/29/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MINNEWASKA COMMUNITY HEALTH SERVICES | 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381 |

| (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 582 | Continued From page 1<br>nursing facility services under the State plan and for which the resident may not be charged;<br>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and<br>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.<br><br>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.<br>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.<br>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.<br>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.<br>(iv) The facility must refund to the resident or resident representative any and all refunds due | F 582 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245537 | A. BUILDING _____ B. WING _____ | 11/29/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MINNEWASKA COMMUNITY HEALTH SERVICES | 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381 |

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|---|---|---|---|---|
| F 582 | Continued From page 2<br>the resident within 30 days from the resident's date of discharge from the facility.<br>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and documentation review, the facility failed to ensure the required notices were given for 3 or 3 residents (R100, R13, R17) whose Medicare A skilled service ended, and remained living at the facility.<br><br>Findings include:<br><br>A review of the Medicare beneficiary notices was conducted on 11/28/18 and revealed the following:<br><br>R100 medical record indicated the facility had provided CMS-10123 Notice of Medicare Non-Coverage (NOMNC), signed 5/19/18, which indicated Medicare A coverage would end on 5/19/18. However, the record lacked documentation the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN, Form CMS-10055) had been provided and R100 discharged from the facility on 5/30/18.<br><br>R13's medical record indicated the facility had provided CMS-10123 Notice of Medicare Non-Coverage (NOMNC) signed 10/27/2018, which indicated R13's Medicare A coverage would end on 10/29/18. However, the record lacked indication the facility provided R13 with the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN, Form CMS-10055) and R13 remained in the facilty on | F 582 | The policy of the Minnewaska Lutheran Home regarding" Medicare and Medicaid Benefits" was reviewed and updated to include providing the Advanced Beneficiary Notice of Non-Coverage (SNF ABN, Form CMS-10055) to all residents who have previously been covered by Medicare A who are remaining in the facility.<br>At this time, there are not residents who have been affected since the correction was put into place.<br>Correction was immediately implemented that all residents who currently are being covered by Medicare A and no longer receiving skilled services but are remaining in the facility are given a CMS-10055 denial. Case Manager, SSD, Administrator, and MDS coordinator were educated on the change made to the policy on Medicare and Medicaid benefits.<br>A weekly audit will be completed for a quarter to monitor that all residents that are receiving Medicare A and are no longer receiving a skilled service have received the Advanced Beneficiary Notice of Non-Coverage (SNF ABN, Form 10055) so that they can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. This will be brought to the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MINNEWASKA COMMUNITY HEALTH SERVICES | 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381 |

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| F 582 | Continued From page 3<br>11/14/18.<br><br>R17's medical record indicated the facility had provided CMS-10123 Notice of Medicare Non-Coverage (NOMNC) signed 11/20/18, which indicated the last day of Medicare A coverage would be 11/22/18. However, the record lacked documentation the facility provided R17 with the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN, Form CMS-10055) and R17 remained in the facility.<br><br>On 11/28/18, at 10:52 a.m. the director of nursing (DON) was interviewed and stated the facility was not aware of the new form SNF ABN, Form CMS-10055. The DON confirmed they had not provided this form to residents 2 days prior to discontinuation of skilled services.<br><br>The facility policy Medicare Beneficiary Notices dated 9/18/17, lacked the correct CMS required SNF ABN, Form CMS-10055 requirements regarding Medicare Beneficiary notice. | F 582 | Quality Assurance Committee Meeting in March, 2019 for further recommendations. | |
| F 623 SS=D | Notice Requirements Before Transfer/Discharge<br>CFR(s): 483.15(c)(3)-(6)(8)<br><br>§483.15(c)(3) Notice before transfer.<br>Before a facility transfers or discharges a resident, the facility must-<br>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.<br>(ii) Record the reasons for the transfer or discharge in the resident's medical record in | F 623 | | 12/13/18 |

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| F 623 | Continued From page 4<br>accordance with paragraph (c)(2) of this section; and<br>(iii) Include in the notice the items described in paragraph (c)(5) of this section.<br><br>§483.15(c)(4) Timing of the notice.<br>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.<br>(ii) Notice must be made as soon as practicable before transfer or discharge when-<br>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;<br>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;<br>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;<br>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or<br>(E) A resident has not resided in the facility for 30 days.<br><br>§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:<br>(i) The reason for transfer or discharge;<br>(ii) The effective date of transfer or discharge;<br>(iii) The location to which the resident is transferred or discharged;<br>(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which | F 623 | | |

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| F 623 | Continued From page 5<br>receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;<br>(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;<br>(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and<br>(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.<br><br>§483.15(c)(6) Changes to the notice.<br>If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.<br><br>§483.15(c)(8) Notice in advance of facility closure<br>In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as | F 623 | | |

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| F 623 | Continued From page 6<br>well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review the facility failed to notify the ombudsman of a facility initiated transfer for 1 of 2 residents (R34) reviewed for hospitalization.<br><br>Findings include:<br><br>R34's admission Minimum Data Set (MDS) dated 8/31/18, identified R34 had severe cognitive impairment and required assistance with activities of daily living (ADLs). The MDS identified R34 had diagnoses which included; acute kidney failure, morbid obesity and hypertension.<br><br>R34's progress note of 9/8/18, identified R34 was transferred to the hospital emergency room (ER).<br><br>Review of social service designee (SSD)-A's fax dated 11/26/18, sent to the Office of Ombudsman for LTC (long term care) included an admit/discharge report of discharges dated 7/4/18, through 9/24/18. The form lacked the facility initiated transfer of R34 to the ER on 9/8/18.<br><br>On 11/28/18, at 3:24 p.m. SSD-A confirmed the fax sent to the Office of Ombudsman for LTC dated 11/26/18, did not include the hospital ER transfer of R34 on 9/8/18. SSD-A confirmed her usual practice did not include notifying the ombudsman of hospital ER transfers.<br><br>On 11/29/18, at 9:04 a.m. Administrator indicated it was his understanding since a training session | F 623 | The policy of the Minnewaska Lutheran Home regarding "Transfer and Discharge Notice" was reviewed and updated to include guidelines for notification of transfer from the facility. For residents being transferred as soon as possible (i.e. hospital) for urgent medical need, the resident and/or representative should be notified as soon as it is practicable but before the transfer from the facility as well as a copy of the notice will be sent to the Office of Long-Term Care Ombudsman. For all other transfers, a copy of the notice will be sent to the Office of Long-Term Care Ombudsman at least 30 days before the resident is transferred or discharged or as practicable before discharge.<br>Correction was immediately implemented that the Office of Long-Term Care Ombudsman will be notified as per timeline indicated in "Transfer and Discharge Notice" for all transfers and discharges from the facility.<br>The SSD was educated on the importance of the policy "Transfer and Discharge Notice" as well as a copy of the regulations for F623 to ensure accurate knowledge of the guidelines.<br>An audit was completed to make sure that all transfers in the last 30 days had notifications sent to the long term care ombudsmen.<br>An audit will be completed bi-weekly for | |

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| F 623 | Continued From page 7<br>he had attended last year, that hospital transfers were not required to be reported to the ombudsman, and indicated the facility had stopped this practice. Administrator indicated the facility would begin to report all facility initiated transfers to the ombudsman.<br><br>The facility policy titled Transfer or Discharge Documentation undated, identified the ombudsman would be notified of all transfers and discharges. | F 623 | one quarter to review all notifications to the Office of Long-Term Care Ombudsman to ensure notification was made. The results of the audit will be brought to the Quality Assurance Committee in March, 2019 for further recommendations. | |
| F 655 SS=D | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- | F 655 | | 12/13/18 |

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| F 655 | Continued From page 8<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).<br><br>§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:<br>(i) The initial goals of the resident.<br>(ii) A summary of the resident's medications and dietary instructions.<br>(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.<br>(iv) Any updated information based on the details of the comprehensive care plan, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours to address the individualized needs for 1 of 2 residents (R30) recently admitted. Additionally, the facility failed to provide a summary of the baseline care plan to the resident or resident representative for 2 of 2 residents (R30, R34) recently admitted.<br><br>Findings include:<br><br>R30's admission Minimum Data Set (MDS) dated 11/5/2018, identified R30 was cognitively intact with some memory issues and had diagnoses which included heart failure, high blood pressure, osteoporosis, anxiety and asthma/chronic lung disease. R30's MDS also indicated R30 required assistance of one staff with activities of daily living | F 655 | It is the policy of the Minnewaska Lutheran Home that "a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission." At this time, all resident recently admitted have been found to have a baseline care plan in place. Education will be provided to all RN's, Case Manager, and MDS coordinator that a baseline (forty-eight hour care plan) needs to be completed within the designated time frame of forty eight hours. The RN will be expected to complete the care plan and present to the resident or designee for approval and signature and be documented to the resident's record, and placed in the chart.<br>An audit will be completed weekly for a | |

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| F 655 | Continued From page 9<br>(ADL).<br><br>R30 was admitted to the facility on 10/29/2018. R30's medical record included a baseline care plan which had been completed on 11/2/2018. R30 signed the baseline care plan on 11/29/2018.<br><br>On 11/29/2018, at 8:17 a.m. R30 stated she couldn't remember if she received a summary of the baseline care plan.<br><br>On 11/29/18, at 8:19 a.m. clinical case manager (CCM)-A stated baseline care plans should be completed and a summary provided to the resident and resident representative within 48 hours after admission. CCM-A reviewed R30's baseline care plan present in the medical record and verified it had not been completed within the 48 hour time frame. CCM-A further verified the baseline care plan had not been signed by R30 or the resident representative. CCM-A stated she couldn't recall why the baseline care plan had not been completed within the required time frame.<br><br>On 11/29/2018, at 9:39 a.m. the director of nursing (DON) indicated baseline care plans shoud be completed within 48 hours after admission. The DON verified R30's baseline care plan had not been completed within the 48 hour time frame.<br><br>R34 | F 655 | month and then monthly X3 months to monitor that all new admissions have base line care plans completed within 48 hours of admission. The results of the audit will be brought to the Quality Assurance Committee in March, 2019 for further recommendations. | |

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| F 655 | Continued From page 10<br><br>R34's admission minimum data set (MDS) dated 8/31/18, identified R34 had severe cognitive impairment and required assistance with activities of daily living (ADLs). R34's MDS further identified he had diagnoses which included; acute kidney failure, morbid obesity and hypertension.<br><br>R34's baseline care plan dated 8/26/18, contained CM-A's signature, but the resident/responsible party signature line was blank. R34's medical record lacked documentation a summary of the baseline care plan was provided to R34 or his representative.<br><br>R34's progress note of 8/26/18, identified that a baseline care plan was completed, and it would be reviewed with family when available.<br><br>On 11/28/18, at 3:14 p.m. CM-A indicated she could not remember if she had provided a copy of the baseline care plan for R34 or his representative, and was unable to provide documentation it had been done. She indicated her usual practice was to have them sign the baseline care plan at the time she provided them with a copy of it.<br><br>On 11/29/18, at 8:57 a.m. DON indicated the usual facility process for baseline care plans included reviewing it with the resident or representative, then providing them a copy of it. DON indicated her expectation would be for the baseline care plan to be completed within 48 hours, have the resident or representative sign it and provide them a copy of it.<br><br>The facility policy titled Care Plan- Temporary revised on 3/18/18, indicated within 48 hours, a | F 655 | | |

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| F 655 | Continued From page 11<br>48 hour care plan would be developed and presented to the resident and family with care and goals as indicated and acceptable. Further, the policy identified the 48 hour care plan would be signed by the resident or family and placed in the chart. | F 655 | | |
| F 688 SS=D | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to implement appropriate interventions related to the use of a contracture boot to maintain or improve range of motion for 1 of 1 residents (R25) who had limited range of motion (ROM).<br><br>Findings include: | F 688 | It is the practice of Minnewaska Lutheran Home to assure ROM and mobility services are provided according to physician's orders and the resident's plan of care to limit or prevent contractures.<br>The policy of the Minnewaska Lutheran Home regarding "Rehabilitative Nursing Care" was reviewed and updated to include that the restorative aide is | 12/17/18 |

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| F 688 | Continued From page 12<br>R25's Face Sheet printed on 11/29/18, identified diagnoses that included hemiplegia (paralysis) and hemiparesis (weakness) affecting left side following a stroke.<br><br>R25's quarterly Minimum Data Set (MDS) dated 10/25/18, indicated R25 had moderate cognitive impairment, and required extensive assistance of activities of daily living (ADLs). The MDS also indicated R25 had a functional impairment of upper and lower extremities on one side.<br><br>R25's care plan dated 5/9/18, R25 was totally dependent on staff and mechanical lift for transfers, and was unable to ambulate. Interventions included: PT/OT (physical therapy/occupational therapy) evaluate and treat as ordered and restorative nursing program as indicated. R25's care plan lacked PRAFO boot interventions.<br><br>R25's nurse practitioner (NP) note dated 8/16/18, directed various instructions which included to continue to use PRAFO (contracture) boot to prevent ankle contracture; ideally would be on 2 hours and off 2 hours, consider AFO if foot turn becomes more of a problem, consider twice a day stretching program including all extremities and cervical spine<br><br>On 11/26/18, at 3:10 p.m. R25 was observed lying in bed and positioned on her back. R25 was observed to have a moderate left hand contracture and had foot drop of the left foot. No splint or device was observed in use with R25 or observed present in the room.<br><br>On 11/26/18, at 7:11 p.m. R25's family member (FM-A) stated R25 had ongoing concerns with | F 688 | available 3-4 times per week to provide services, and the rehabilitative nursing care is available daily.<br>Resident R25 orders for a PARFO boot , that were contained in a progress note, have been processed. Resident Assessment completed and noted no contracture present in bilateral ankles. (Lt.) ankle is flaccid and no resistance noted in the (Rt.) ankle. PARFO boot obtained from therapy and will be utilized 2 hours on and 2 hours off per physician's orders. Staff will continue to assess for resistance in bilateral ankles. Resident continues to receive ROM from Restorative Aide 3-4 times per week per Care Plan.<br>All residents records/progress notes will be reviewed to assure that if there are recommendations from therapy or physician's orders, that the services are being provided.<br>Education has been provided that a review of all progress notes be made by the licensed/registered nurse to assure that further order, if contained in the progress note, are processed and implemented as ordered.<br>An audit will be completed weekly for a month and then monthly X 3 months to ensure that all orders received are being processed and implemented. The results of the audit will be brought to the Quality Assurance Committee for further recommendations. | |

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| F 688 | Continued From page 13 | F 688 | | |

contractures and left foot drop. He was aware restorative nursing was seeing R25, he believed it was 7 days per week, but was unaware of any further interventions to treat R25's foot drop or contractures.

On 11/27/18, at 8:24 a.m. R25 was observed lying in bed, with a feeding tube bag hanging next to the bed. R25 was not observed to wear a splint or device on the hand contracted hand or left foot which had observed foot drop. .

On 11/28/18, at 11:19 a.m. nursing assistant (NA)-B indicated R25 received ROM exercises from the restorative program 3-4 times per week. NA-B stated R25 had never had a splint for the foot or hand in place to wear.

On 11/29/18, at 9:44 a.m. RN-A stated R25 had a stroke and had impairment of the left side hand and foot. RN-A stated R25 had previously received PT/OT services and had been discharged to continue on the restorative nursing program. RN-A confirmed the note for use of the PRAFO boot order on 8/6/18, and stated the order should have been implemented.

On 11/29/18, at 10:23 a.m. the director of nursing (DON) indicated R25 had received therapy until goals were met and then R25 received restorative nursing 3-4 times per week. DON confirmed R25 had an order for the use of a PRAFO boot. DON indicated she would expect all orders to be implemented and also indicated the therapist should have been contacted to assist with implementation of the PRAFO boot order.

The facility policy titled Rehabilitative Nursing Care, reviewed 12/3/15, identified rehabilitative

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 688 | Continued From page 14<br>nursing care was performed daily for residents who required those services. The policy included programs listed which included: routine range of motion exercises,maintenance of good body alignment, proper positioning and other treatments as ordered by physician. The policy further identified rehabilitative nursing care goals would be identified on the resident's care plan, reviewed by the case manager and changed as needed. | F 688 | | |
| F 880 SS=F | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, | F 880 | | 12/18/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245537 | A. BUILDING _____ B. WING _____ | 11/29/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MINNEWASKA COMMUNITY HEALTH SERVICES | 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381 |

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| F 880 | Continued From page 15<br>but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary. | F 880 | | |

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| F 880 | Continued From page 16<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to establish an infection control program which included comprehensive concurrent surveillance and analysis of possible patterns of infection in the facility. This deficient practice had the potential to affect all 33 residents who resided in the facility.<br><br>Findings include:<br><br>The Minnewaska Community Health Services infection control surveillance program was reviewed on 11/29/2018. The facility utilized a document titled "Minnewaska Lutheran Home Infection Control Tracking Log." The tracking log was used for antibiotic surveillance on the A/B and C wings and included the following columns: Resident, First day and last day of medication, Diagnosis (& site if applicable), Medication & dose, Frequency and number of days, Organism/culture done, Admit or readmit, Symptoms not treated with Rx (GI or cold), Does resident have a catheter? (UTI only), and a comments section. The monthly logs included only the residents with infections for which antibiotics/antiviral's were prescribed, and did not include symptoms assessed/criteria for the infections treated with antibiotics or potentially infectious symptoms for those currently not being treated with antibiotics/antiviral's, with no data recorded in the "Symptoms not treated with Rx (GI or cold) section. The log also lacked indication if the infections were community acquired or nosocomial.<br><br>Review of the facility forms titled Minnewaska Community Health Services Infection Control | F 880 | The Minnewaska Lutheran Home has a policy regarding "Surveillance for infections". As part of this policy, the Infection Preventionist will collect data on a document that includes all antibiotic treated infections as well as potential communicable diseases that may not be treated with an antibiotic such as those resident who may have symptoms of nausea and vomiting, upper respiratory congestion, and other symptoms with the potential to be contagious. The data will be compiled and reviewed daily for potential outbreaks in the facility. The Infection Preventionist has created a new tracking form that will include all antibiotic treated infections as well as those with symptoms that is not being treated with an antibiotic but has potential to be contagious for tracking this data.<br>On the days that the Infection Preventionist is not here, the RN on duty will review the tracking form and initial off that a review has been completed. Any concerns will be addressed to the resident's attending physician.<br>All nursing staff were notified via email on 12/18/18 of the new process that has been implemented along with instructions on the purpose and use of the form. All staff will be educated at an all staff in-service on 01/08/2019 along with a review of the survey results.<br>An audit will be completed weekly for a month and then monthly x 3 months to review that the procedure is being followed and any issues with outbreaks | |

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| F 880 | Continued From page 17<br>Tracking Log from 5/18, through 10/18, identified the following:<br><br>-5/18, 6 entries and included: 4 Urinary Tract Infections (UTI's), 1 conjunctivitis (eye infection), and 1 pneumonia, all were prescribed antibiotics. All 6 entries were without indicated symptoms/number of symptoms prior to start of an antibiotics. 3 of the 6 entries failed to include data on a culture being done, and failed to identify the infectious organism.<br><br>-6/18: 11 entries and included: 4 UTI's, 2 pneumonia, 1 osteomyelitis (an infection of the bone), 1 C-difficile, 1 conjunctivitis, all were prescribed antibiotics. In addition, 2 antibiotics were prescribed for congestion and Chronic Obstructive Pulmonary Disease (COPD) exacerbation with no diagnosis or culture. All 11 entries were without indicated symptoms/number of symptoms prior to start of an antibiotic/antiviral. 4 of the 11 entries failed to include data on a culture being done, and failed to identify the infectious organism.<br><br>-7/18: 10 entries and included: 4 respiratory infections (bronchitis, bronchial pneumonia, and pneumonia), 2 UTI's, and 3 eye infections, all were treated with antibiotics. All 10 entries were without indicated symptoms/number of symptoms prior to start of an antibiotics. 9 of the 10 entries failed to include data if a culture had been done, and failed to identify the infectious organism.<br><br>-8/18: 22 entries and included: 11 respiratory infections (bronchitis, bronchial pneumonia, and pneumonia), 4 conjunctivitis, 4 UTI's, and 1 wound infection, all treated with antibiotics. In addition, the log included 1 shingles and 1 herpes | F 880 | have been addressed. The results of the audits will be brought to the Quality Assurance Committee Meeting in March, 2019 for further recommendations. | |

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| F 880 | Continued From page 18 | F 880 | | |

infection which were treated with Valtrex. All 22 entries were without indicated symptoms/number of symptoms prior to start of an antibiotic/antiviral's being prescribed. 16 of the 22 entries failed to include data on a culture being done, and failed to identify the infectious organism.

-9/18: The log included 6 entries as follows: 4 pneumonia, 1 UTI, and 1 gangrenous heel infection all six entries were without indicated symptoms/number of symptoms prior to start of antibiotics. 4 of the 6 entries failed to include data on a culture being done, and all 6 entries failed to identify the infectious organism.

-10/18: 10 entries included: 4 pneumonia and 1 aspiration, 1 C-difficile, and 3 UTI's all without indicated symptoms/number of symptoms prior to start of antibiotics. 8 of the 10 entries failed to include data on a culture being done, and all 10 entries failed to identify the infectious organism.

-11/18: No log was provided.

On 11/29/18, at 2:03 p.m. Infection Preventionist - registered nurse (IP-RN)-A. IP-RN stated residents who were prescribed an antibiotic were put on the tracking form by the nurse working the floor. IP-RN further explained the nurse filled in the medication, dose, and start/stop dates. IP-RN further indicated she gathered the sheets at the end of the month to compile the data to create a monthly summary report of any trends or correlation between staff and resident illness. When asked how the facility would track potentially infectious symptoms for residents who were not prescribed antibiotics the IP-RN stated that she or the RN on duty that day reviewed the

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| F 880 | Continued From page 19<br>progress notes daily. IP-RN indicated if there was a concern for a trend of illness symptoms they would notify the DON, and they would review the information and implement precautions as needed. IP-RN verified they only utilized the tracking system for resident infections that have been prescribed antibiotics. IP-RN indicated if there was an increase or concern of an outbreak in the community the clinic would instruct the facility to restrict visitors. IP-RN verified that viral symptoms, fevers, fungal infections, skin issues, cold/gastrointestinal (GI) diarrhea/vomiting symptoms or other potentially infectious symptoms were not tracked in any formal way, but by daily review of the progress notes.<br><br>The facility policy titled Infection Prevention revised 12/10/15, indicated the facilities infection prevention policies and procedures are to establish guidelines to follow to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection. The policy interpretation and implementation objective was to prevent, recognize, investigate, and control to the extent possible the onset and spread of infection within the facility.<br><br>In addition, the facility provided document titled Criteria for Defining Infections in LTC Facilities reviewed on 1/4/13, was a tool used for surveillance of symptoms of infection such as change in mental, and functional status | F 880 | | |
| F 912 SS=E | Bedrooms Measure at Least 80 Sq Ft/Resident CFR(s): 483.90(e)(1)(ii)<br><br>§483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at | F 912 | | 12/20/18 |

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| F 912 | Continued From page 20<br>least 100 square feet in single resident rooms; This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure the 15 resident rooms on the A-wing had at least 100 square feet of useable floor space for 12 of 15 residents (R5, R6, R7, R9, R16, R18, R20, R23, R27, R28, R32, R33) who currently resided in those rooms.<br><br>Findings include:<br><br>During the A-wing tour on 11/29/18, at 9:02 a.m. with the maintenance director (MD)-A R5, R6, R7, R9, R16, R18, R20, R23, R27, R28, R32, and R33's rooms were observed to not have at least 100 square feet of useable floor space, as required.<br><br>On 11/26/18, at 12:52 p.m. R9 indicated her room was small, however she did not want to move to another room.<br>-At 12:59 p.m. R28 was observed to be laying in bed. The room appeared neat and orderly. R28 was not able to respond to questions about his room.<br>- At 1:05 p.m. R6 had no concerns regarding the size of his room and stated the room accommodated his needs.<br>- At 1:09 p.m. R32 stated his room was fine and had no concerns with the size of the room.<br>- At 1:12 p.m. R23 indicated his room was fine and accommodated his needs.<br>- At 1:15 p.m. R7 stated she had no concerns with the size of her room.<br>- At 1:26 p.m. R5 indicated she had been at the facility for awhile and that her room was okay. R5 further confirmed she had enough room to get around. | F 912 | An application for a waiver has been requested: in rooms A 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, and 36 are 95.68 to 960.7 square feet of usable space and do not meet the minimum requirements of at least 100 square feet of usable space. Formally complying bedrooms were reduced in area to accommodate expanded toilet rooms. A previous waiver was requested. | |

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| F 912 | Continued From page 21<br>- At 1:30 p.m. R16 indicated he liked his room due to the nice view and didn't have any concerns regarding the size of the room.<br>- At 1:52 p.m. R20 stated his room was fine and there was adequate space for him.<br>- At 1:56 p.m. R18 indicated her room was okay.<br>On 11/29/18, at 9:02 a.m. R33 was observed to be laying in bed. The room appeared neat and orderly. R33 was unable to respond to questions regarding his room.<br>-At 9:05 a.m. R27 was observed to be laying in bed. The room appeared neat and orderly. R27 was unable to respond to questions about his room.<br><br>The following rooms on the A-wing were unoccupied: 27, 29 and 30.<br><br>On 11/29/18, at 9:02 a.m. MD-A confirmed the single rooms on the A-wing were less than the required 100 square feet of useable floor space. He verified with a diagram that the floor space of Wing A rooms were between 95.68 and 96.07 square feet. MD-A indicated when the bathrooms were remodeled the resident rooms became too small. He indicated the facility would be applying for a waiver.<br><br>On 11/29/18, at 9:57 a.m. director of nursing (DON) stated the facility offered a room change to R9 and she declined the offer. R9 indicated to the DON she wanted to stay in her current room. DON further stated she had not received other complaints from residents regarding the small room size.<br><br>On 11/29/18, at 10:21 a.m. the administrator verified the rooms were smaller than the required 100 square feet due to the past bathroom | F 912 | | |

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| F 912 | Continued From page 22<br>remodel that had been completed. Administrator indicated there had been no concerns expressed by the residents about the room size. The administrator stated the facility would be reapplying for a new waiver. | F 912 | | |

Minnewaska Community Health Services
a community of services grounded in faith

December 20, 2018

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537

Dear Ms. Anderson:

Please accept this letter as our request to ask for a Federal waiver for the deficiency cited during our standard state survey completed by the Minnesota Department of Health and Public Safety on November 26, 2018. The waiver request is in response to the following Federal Deficiency:

1. F 912 Bedrooms Measure at least 100 Sq. Feet for one bed, private bedrooms.

A waiver has been previously reviewed and approved at the Minnesota Department of Health.

A Wing rooms: 36,35,34,33,32,31,29,28,27,26,25, and 24

Residents: R9, R33, R28, R32, R6, R23, R7, R5, R16, R20, R18, R27

A previous remodeling and expansion of the toileting rooms on the "A" wing resulted in a slightly reduced useable floor area in the rooms thus the need for a waiver.

The facility recognizes that the square footage in the A wing for the private one bed rooms noted are between 95.68 to 96.07 square feet and will work to address the comments/concerns noted by residents in the deficiency.

If you have any questions or concerns, please feel free to contact me.

Sincerely,

Christopher Knoll, Administrator
Minnewaska Community Health Services
Phone: (320) 239-7104 Email: cknoll@mchs-healthcare.org

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|---|---|---|---|
| | 245537 | A. BUILDING **01 - 01 - 1960 BUILDING AND ADDITIONS**<br>B. WING _____ | **11/28/2018** |

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| K 000 | INITIAL COMMENTS<br><br>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.<br><br>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.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on November 28, 2018. At the time of this survey, Building 01 of Minnewaska Community Health Services Nursing Home was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.<br><br>IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES<br>( K-TAGS) TO: | K 000 | EPOC | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 12/20/2018 |

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

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| K 000 | Continued From page 1 | K 000 | | |

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

By email to:
FM.HC.Inspections@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.

Minnewaska Community Health Services Nursing Home is a one-story building with no basement, and is fully fire sprinkler protected throughout. The original 1960 building along with the 1968 and 1972 additions were determined to be of Type II(111) construction. The 1988 and 1996 building additions were determined to be of Type V(111) construction. The 2000 building addition was determined to be of Type II(111) construction.

The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 43 beds and had a census of 34 at time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is

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|---|---|---|---|---|
| K 000 | Continued From page 2<br>NOT MET as evidenced by: | K 000 | | |
| K 271 SS=E | Discharge from Exits<br>CFR(s): NFPA 101<br><br>Discharge from Exits<br>Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview the facility failed to keep exits free of obstructions as stated in the Life Safety Code (NFPA 101) 2012 edition sections 19.2.7 & 7.1.10. This deficient practice could restrict the exiting during an emergency and affect 43 of the 43 residents and an undetermined amount of staff and visitors.<br><br>Findings Include:<br><br>On the facility tour between 9:30 AM and 12:30 PM on 11/28/2018, observations revealed the following:<br><br>1. There was a difference of more than 3/4 inch between the concrete slabs of the sidewalk on the end of the "C" Wing.<br><br>This deficient conditions was confirmed by the Director of Maintenance. | K 271 | Installed an aluminum threshold 6' X 6" to meet ADA requirements for the 3/4" difference between concrete slabs. | 12/4/18 |
| K 324 SS=D | Cooking Facilities<br>CFR(s): NFPA 101 | K 324 | | 12/4/18 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245537 | A. BUILDING **01 - 01 - 1960 BUILDING AND ADDITIONS** B. WING _____ | **11/28/2018** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **MINNEWASKA COMMUNITY HEALTH SERVICES** | **605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| K 324 | Continued From page 3<br><br>Cooking Facilities<br>Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:<br>* residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2<br>* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or<br>* cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.<br>Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.<br>18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on a review of documentation and an interview with staff, it was determined that the kitchen hood suppression system is not in accordance with NFPA 101 The Life Safety Code (edition 2012), Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. This deficient practice could affect all residents and an undetermined amount of visitors. | K 324 | Summit has dedicated a service person to Minnewaska Lutheran Home to monitor and stay in compliance with cooking hood semi-annual inspections. Monitoring has been placed on preventive maintenance program. | |

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| K 324 | Continued From page 4<br><br>Findings Include:<br>During the documentation review between 9:30 AM to 12:30 PM on 11/28/2018, observations revealed that the testing on the hood system did not happen in a timely manner between the semi-annuals. Dates the hood system was tested are 04/17/18 and 11/15/2018.<br><br>This deficient conditions was confirmed by the Director of Maintenance. | K 324 | | |
| K 353 SS=F | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to test and maintain the sprinkler system in accordance with the 2012 Life Safety | K 353 | Nova Sprinkler Company will be replacing the corroded sprinkler heads when parts arrive on or about the week of | 12/28/18 |

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| | 245537 | A. BUILDING **01 - 01 - 1960 BUILDING AND ADDITIONS** B. WING _____ | **11/28/2018** |

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| K 353 | Continued From page 5<br>Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all of the 43 residents and an undetermined amount of staff and visitors.<br><br>Findings include:<br><br>On the facility tour between 9:30 AM and 12:30 PM on 11/28/2018 observations revealed 2 corroded sprinkler heads in the kitchen and 1 in the utility closet F106.<br><br>This deficient conditions was confirmed by the Director of Maintenance. | K 353 | 12/24/2018. Parts had to be ordered with a 3 week delivery time. | |
| K 524 SS=F | HVAC - Direct-Vent Gas Fireplaces<br>CFR(s): NFPA 101<br><br>Direct-Vent Gas Fireplaces<br>Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to provide the proper protection of a gas appliance in accordance with NFPA 101 (2012) section 19.5.2.3 item 2(d). This deficient practice could affect all residents, staff and visitors. | K 524 | Screen has been purchased and installed in front of fire place. | 12/17/18 |

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| **MINNEWASKA COMMUNITY HEALTH SERVICES** | **605 MAIN STREET, PO BOX 40**<br>**STARBUCK, MN 56381** |

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| K 524 | Continued From page 6<br><br>Findings include:<br><br>On the facility tour between 9:30 AM and 12:30 PM on 11/28/2018, observations revealed the screen on the fireplace in the fireside lounge was excessively hot to the touch and was not properly protected.<br><br>This deficient conditions was confirmed by the Director of Maintenance. | K 524 | | |
| K 914 SS=F | Electrical Systems - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Electrical Systems - Maintenance and Testing<br>Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results.<br>6.3.4 (NFPA 99)<br>This REQUIREMENT is not met as evidenced by: | K 914 | | 12/5/18 |

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| K 914 | Continued From page 7<br>Based on record review and staff interview, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect 43 of 43 residents as well as an undetermined number of staff, and visitors to the facility.<br><br>Findings include:<br><br>On the facility tour between 9:30 AM and 12:30 PM on 11/28/2018, record review revealed there was no documentation for the annual receptacle inspection in resident rooms.<br><br>This deficient conditions was confirmed by the Director of Maintenance. | K 914 | All plug-ins in resident sleeping areas were tested on 12/05/2018. A digital scale has been purchased to check the 4 oz minimum requirement of the group blade on each electrical receptacle. Testing will be completed annually per requirements. | |

Electronically delivered
December 13, 2018

Administrator
Minnewaska Community Health Services
605 Main Street, Po Box 40
Starbuck, MN 56381

Re: State Nursing Home Licensing Orders - Project Number S5537031

Dear Administrator:

The above facility was surveyed on November 26, 2018 through November 29, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF

CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

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 |
|---|---|---|---|
| | 00477 | A. BUILDING: _____ B. WING _____ | 11/29/2018 |

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| MINNEWASKA COMMUNITY HEALTH SERVICE | 605 MAIN STREET, PO BOX 40 STARBUCK, MN 56381 |

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

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| 2 000 | Continued From page 1<br><br>Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.<br><br>On 11/26/18, to 11/29/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.<br><br>The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. | 2 000 | | |

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| 2 000 | Continued From page 2<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | | |
| 2 895 | MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion<br><br>Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:<br><br>B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to implement appropriate interventions related to the use of a contracture boot to maintain or improve range of motion for 1 of 1 residents (R25) who had limited range of motion (ROM).<br><br>Findings include:<br><br>R25's Face Sheet printed on 11/29/18, identified diagnoses that included hemiplegia (paralysis) and hemiparesis (weakness) affecting left side following a stroke. | 2 895 | "Corrected" | 12/17/18 |

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| 2 895 | Continued From page 3<br><br>R25's quarterly Minimum Data Set (MDS) dated 10/25/18, indicated R25 had moderate cognitive impairment, and required extensive assistance of activities of daily living (ADLs). The MDS also indicated R25 had a functional impairment of upper and lower extremities on one side.<br><br>R25's care plan dated 5/9/18, R25 was totally dependent on staff and mechanical lift for transfers, and was unable to ambulate. Interventions included: PT/OT (physical therapy/occupational therapy) evaluate and treat as ordered and restorative nursing program as indicated. R25's care plan lacked PRAFO boot interventions.<br><br>R25's nurse practitioner (NP) note dated 8/16/18, directed various instructions which included to continue to use PRAFO (contracture) boot to prevent ankle contracture; ideally would be on 2 hours and off 2 hours, consider AFO if foot turn becomes more of a problem, consider twice a day stretching program including all extremities and cervical spine<br><br>On 11/26/18, at 3:10 p.m. R25 was observed lying in bed and positioned on her back. R25 was observed to have a moderate left hand contracture and had foot drop of the left foot. No splint or device was observed in use with R25 or observed present in the room.<br><br>On 11/26/18, at 7:11 p.m. R25's family member (FM-A) stated R25 had ongoing concerns with contractures and left foot drop. He was aware restorative nursing was seeing R25, he believed it was 7 days per week, but was unaware of any further interventions to treat R25's foot drop or contractures. | 2 895 | | |

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| 2 895 | Continued From page 4<br><br>On 11/27/18, at 8:24 a.m. R25 was observed lying in bed, with a feeding tube bag hanging next to the bed. R25 was not observed to wear a splint or device on the hand contracted hand or left foot which had observed foot drop. .<br><br>On 11/28/18, at 11:19 a.m. nursing assistant (NA)-B indicated R25 received ROM exercises from the restorative program 3-4 times per week. NA-B stated R25 had never had a splint for the foot or hand in place to wear.<br><br>On 11/29/18, at 9:44 a.m. RN-A stated R25 had a stroke and had impairment of the left side hand and foot. RN-A stated R25 had previously received PT/OT services and had been discharged to continue on the restorative nursing program. RN-A confirmed the note for use of the PRAFO boot order on 8/6/18, and stated the order should have been implemented.<br><br>On 11/29/18, at 10:23 a.m. the director of nursing (DON) indicated R25 had received therapy until goals were met and then R25 received restorative nursing 3-4 times per week. DON confirmed R25 had an order for the use of a PRAFO boot. DON indicated she would expect all orders to be implemented and also indicated the therapist should have been contacted to assist with implementation of the PRAFO boot order.<br><br>The facility policy titled Rehabilitative Nursing Care, reviewed 12/3/15, identified rehabilitative nursing care was performed daily for residents who required those services. The policy included programs listed which included: routine range of motion exercises,maintenance of good body alignment, proper positioning and other treatments as ordered by physician. The policy further identified rehabilitative nursing care goals | 2 895 | | |

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| 2 895 | Continued From page 5<br>would be identified on the resident's care plan, reviewed by the case manager and changed as needed.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policy and procedures and inservice nursing staff on those policies, to ensure residents received appropriate treatment was provided to maintain ROM, and then audit to ensure compliance. The results could be reviewed as part of the overall quality assurance committee plan.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 895 | | |
| 21375 | MN Rule 4658.0800 Subp. 1 Infection Control; Program<br><br>Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to establish an infection control program which included comprehensive concurrent surveillance and analysis of possible patterns of infection in the facility. This deficient practice had the potential to affect all 33 residents who resided in the facility.<br><br>Findings include:<br><br>The Minnewaska Community Health Services | 21375 | "Corrected" | 12/17/18 |

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| | 00477 | A. BUILDING: _____ B. WING _____ | 11/29/2018 |

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| 21375 | Continued From page 6 | 21375 | | |

infection control surveillance program was reviewed on 11/29/2018. The facility utilized a document titled "Minnewaska Lutheran Home Infection Control Tracking Log." The tracking log was used for antibiotic surveillance on the A/B and C wings and included the following columns: Resident, First day and last day of medication, Diagnosis (& site if applicable), Medication & dose, Frequency and number of days, Organism/culture done, Admit or readmit, Symptoms not treated with Rx (GI or cold), Does resident have a catheter? (UTI only), and a comments section. The monthly logs included only the residents with infections for which antibiotics/antiviral's were prescribed, and did not include symptoms assessed/criteria for the infections treated with antibiotics or potentially infectious symptoms for those currently not being treated with antibiotics/antiviral's, with no data recorded in the "Symptoms not treated with Rx (GI or cold) section. The log also lacked indication if the infections were community acquired or nosocomial.

Review of the facility forms titled Minnewaska Community Health Services Infection Control Tracking Log from 5/18, through 10/18, identified the following:

-5/18, 6 entries and included: 4 Urinary Tract Infections (UTI's), 1 conjunctivitis (eye infection), and 1 pneumonia, all were prescribed antibiotics. All 6 entries were without indicated symptoms/number of symptoms prior to start of an antibiotics. 3 of the 6 entries failed to include data on a culture being done, and failed to identify the infectious organism.

-6/18: 11 entries and included: 4 UTI's, 2 pneumonia, 1 osteomyelitis (an infection of the

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| 21375 | Continued From page 7 | 21375 | | |

bone), 1 C-difficile, 1 conjunctivitis, all were prescribed antibiotics. In addition, 2 antibiotics were prescribed for congestion and Chronic Obstructive Pulmonary Disease (COPD) exacerbation with no diagnosis or culture. All 11 entries were without indicated symptoms/number of symptoms prior to start of an antibiotic/antiviral. 4 of the 11 entries failed to include data on a culture being done, and failed to identify the infectious organism.

-7/18: 10 entries and included: 4 respiratory infections (bronchitis, bronchial pneumonia, and pneumonia), 2 UTI's, and 3 eye infections, all were treated with antibiotics. All 10 entries were without indicated symptoms/number of symptoms prior to start of an antibiotics. 9 of the 10 entries failed to include data if a culture had been done, and failed to identify the infectious organism.

-8/18: 22 entries and included: 11 respiratory infections (bronchitis, bronchial pneumonia, and pneumonia), 4 conjunctivitis, 4 UTI's, and 1 wound infection, all treated with antibiotics. In addition, the log included 1 shingles and 1 herpes infection which were treated with Valtrex. All 22 entries were without indicated symptoms/number of symptoms prior to start of an antibiotic/antiviral's being prescribed. 16 of the 22 entries failed to include data on a culture being done, and failed to identify the infectious organism.

-9/18: The log included 6 entries as follows: 4 pneumonia, 1 UTI, and 1 gangrenous heel infection all six entries were without indicated symptoms/number of symptoms prior to start of antibiotics. 4 of the 6 entries failed to include data on a culture being done, and all 6 entries failed to identify the infectious organism.

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| 21375 | Continued From page 8<br><br>-10/18: 10 entries included: 4 pneumonia and 1 aspiration, 1 C-difficile, and 3 UTI's all without indicated symptoms/number of symptoms prior to start of antibiotics. 8 of the 10 entries failed to include data on a culture being done, and all 10 entries failed to identify the infectious organism.<br><br>-11/18: No log was provided.<br><br>On 11/29/18, at 2:03 p.m. Infection Preventionist - registered nurse (IP-RN)-A. IP-RN stated residents who were prescribed an antibiotic were put on the tracking form by the nurse working the floor. IP-RN further explained the nurse filled in the medication, dose, and start/stop dates. IP-RN further indicated she gathered the sheets at the end of the month to compile the data to create a monthly summary report of any trends or correlation between staff and resident illness. When asked how the facility would track potentially infectious symptoms for residents who were not prescribed antibiotics the IP-RN stated that she or the RN on duty that day reviewed the progress notes daily. IP-RN indicated if there was a concern for a trend of illness symptoms they would notify the DON, and they would review the information and implement precautions as needed. IP-RN verified they only utilized the tracking system for resident infections that have been prescribed antibiotics. IP-RN indicated if there was an increase or concern of an outbreak in the community the clinic would instruct the facility to restrict visitors. IP-RN verified that viral symptoms, fevers, fungal infections, skin issues, cold/gastrointestinal (GI) diarrhea/vomiting symptoms or other potentially infectious symptoms were not tracked in any formal way, but by daily review of the progress notes. | 21375 | | |

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| 21375 | Continued From page 9<br><br>The facility policy titled Infection Prevention revised 12/10/15, indicated the facilities infection prevention policies and procedures are to establish guidelines to follow to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection. The policy interpretation and implementation objective was to prevent, recognize, investigate, and control to the extent possible the onset and spread of infection within the facility.<br><br>In addition, the facility provided document titled Criteria for Defining Infections in LTC Facilities reviewed on 1/4/13, was a tool used for surveillance of symptoms of infection such as change in mental, and functional status<br><br>SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to a comprehensive infection control program, to include tracking, trending and investigating all illnesses in the facility. The quality assessment and assurance committee could perform random audits to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty (21) days. | 21375 | | |
| 21710 | MN Rule 4658.1415 Subp. 7 Plant Housekeeping, Operation, & Maintenance<br><br>Subp. 7. Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at | 21710 | | 11/30/18 |

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| 21710 | Continued From page 10<br>the fixtures.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure an environment that was free of accident hazards, related to resident bathroom hot water temperatures in 2 of 3 resident halls. This had the potential to effect all 27 residents who currently resided in those halls.<br><br>Finding include:<br><br>On 11/26/18, at 5:40 p.m. room water temperatures were reviewed with the maintenance worker (MW)-A in all three resident hallways of the building. Water temperatures in resident bathroom sinks on the A and C wing were found to be greater than 115 degrees Fahrenheit (F)<br><br>On 7/26/18, at 5:48 p.m. MW-A and surveyor measured hot water temperatures in the A and C wing resident bathrooms with the facility thermometer taken by MW-A. MW-A verified the water temperatures were too warm, and he indicated the temperatures were to be kept between 105 and 115 degrees F.<br><br>The following water temperatures were measured in the resident bathroom sinks:<br>C wing rooms 101-116:<br>-rooms 101/103 shared bathroom was 117.3 degrees F<br>-rooms 102/104 shared bathroom was 117.4 degrees F<br>-rooms 105/107 shared bathroom was 116.8 degrees F<br>-rooms 106/108 shared bathroom was 117.3 | 21710 | "Corrected" | |

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| 21710 | Continued From page 11<br>degrees F<br>-rooms 109/111 shared bathroom was 117.0<br>degrees F<br>-rooms 110/112 shared bathroom was 116.6<br>degrees F<br>-room 113 was 116.4<br>-room 114 was 116.8<br>-room 115 was 116.6<br>-room 116 was 116.4<br><br>A wing rooms 25 through 38:<br>-room 24 was 117.0<br>-rooms 25/27 shared bathroom was 118.0<br>-rooms 26/28 shared bathroom was 118.1<br>-rooms 29/31 shared bathroom was 116.8<br>-rooms 30/32 shared bathroom was 116.7<br>-rooms 33/35 shared bathroom was 115.8<br>-rooms 34/36 shared bathroom was 115.5<br><br>During this time, MW-A indicated the usual facility practice was to keep the temperatures at 112 degrees F. MW-A verified the hot water temperatures on A and C wing were too hot and he indicated he would not want residents to use the water that hot. MW-A indicated he checked the temperatures randomly on different wings monthly and if he noted the temperature was too hot he would turn down the hot water heater in the boiler room. MW-A indicated he usually measured the temperatures around 3 p.m., but indicated he may need to vary the times of day he measured the temperatures. MW-A indicated wing A and C were the oldest part of the facility building. MW-A indicated he would turn the hot water temperature down and recheck the water temperatures in the morning.<br><br>Facility form titled Resident Room Water Temp/Fan Exhaust undated, identified one room was checked monthly 11/20/17, to 11/14/18. | 21710 | | |

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| 21710 | Continued From page 12<br><br>Temperatures ranged from 112 to 115, with one entry of 1/25/18, room A 25 at 117.<br><br>On 11/27/18, at 8:25 a.m. environmental services director (ESD)-A indicated the usual facility practice was for MW-A to test water temps every month, generally in the afternoon. ESD-A indicated the hot water temperatures may have gone up due to the boiler adjustments made for the season. At 9:11 a.m. ESD-A reported he just completed hot water measurements on some random bathrooms on A and C wing and found the temperatures to be below 115 F.<br><br>The facility policy titled Water Temperatures, Safety of, dated 10/1/18 identified tap water in the facility shall be kept within a temperature range to prevent scalding of residents. The policy further instructed water heaters that service resident rooms, bathrooms, common areas and tub/shower areas shall be set to temperatures of no more than 115 degrees F, or the maximum allowable temperature per state regulation. The policy further indicated direct-care staff shall be informed of risk factors for scalding/burns that are common in the elderly, such as: decreased skin thickness, decreased skin sensitivity, peripheral neuropathy, reduced reaction time, decreased cognition, decreased mobility and decreased communication.<br><br>SUGGESTED METHOD FOR CORRECTION: The Environmental Services Director or designee could monitor and develop a system to log the daily temperature checks, educate staff on the policies and audit on a weekly basis to ensure water temperatures are between 105 and 115 degrees Fahrenheit.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one | 21710 | | |

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| 21710 | Continued From page 13<br>(21) days. | 21710 | | |