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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: P4PW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00725

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245243**
2.STATE VENDOR OR MEDICAID NO.
(L2) **375340900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRANITE MANOR**
(L4) **250 JORDAN DRIVE**
(L5) **GRANITE FALLS, MN** (L6) **56241**

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 **01/15/2018** (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 **48** (L18)
13.Total Certified Beds **48** (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 ___ 6. Scope of Services Limit
___ 3. 24 Hour RN ___ 7. Medical Director
___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size
___ 5. Life Safety Code ___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	48			
(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 :
Nicole Osterloh, Supervisor 01/23/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/23/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/06/1981
(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245243

January 23, 2019

Administrator
Granite Manor
250 Jordan Drive
Granite Falls, MN 56241

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 January 7, 2019 the above facility is certified for:

48 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 48 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 23, 2019

Administrator
Granite Manor
250 Jordan Drive
Granite Falls, MN 56241

RE: Project Number S5243031

Dear Administrator:

On December 28, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for, a standard survey, completed on December 6, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 15, 2019, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 14, 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 survey, completed on December 6, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 7, 2019. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 6, 2018, effective January 7, 2019 and therefore remedies outlined in our letter to you dated December 28, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: P4PW

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Facility ID: 00725

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(L4) **250 JORDAN DRIVE**
(L5) **GRANITE FALLS, MN** (L6) **56241**

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 **12/06/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
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03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
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FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

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Compliance Based On:
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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
	48			
(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 :
Lois Boerboom, HFE NE II 01/11/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/16/2019 (L20)

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

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

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3. Both of the Above :
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07/06/1981
(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

Administrator
Granite Manor
250 Jordan Drive
Granite Falls, MN 56241

RE: Project Number S5243031

Dear Administrator:

On December 6, 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 15, 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:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

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 6, 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 June 6, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245243	A. BUILDING _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE MANOR	250 JORDAN DRIVE GRANITE FALLS, MN 56241

(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 A survey for CMS Emergency Preparedness Requirements was conducted on 12/3/18 through 12/6/18, during a recertification survey. Granite Manor was found to be IN COMPLIANCE with the CMS Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 12/3/18 through 12/6/2018, a standard survey was completed at your facility by the Minnesota Department of Health. Granit Manor was found NOT in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility-	F 791		12/28/18

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

Electronically Signed | 01/02/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245243	A. BUILDING _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE MANOR	250 JORDAN DRIVE GRANITE FALLS, MN 56241

(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 791	Continued From page 1 §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dental services	F 791	On 12/13/18 a nursing department meeting was held education was provided	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245243	A. BUILDING _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 791	Continued From page 2 were provided for 1 of 1 resident (R17). Findings include: Record review indicated R17's was admitted on 9/17/18. R17's diagnoses including: paraplegia (paralysis on 1 side of the body), osteomyelitis (bone infection), stage 4 coccyx (tailbone area) pressure ulcer, and muscle wasting. An undated mouth (oral cavity) diagram, indicated R17 had multiple missing teeth, denied mouth pain, completed cleaning habits every once in a while when he felt like it, was not currently seeing a dentist, and had not seen a dentist in three to four years. A 9/17/18, oral cavity assessment in the electronic health record (EHR), indicated R17 had his own teeth which were in poor condition, and had some or all natural tooth loss. The assessment indicated there was no referral made to a dentist, and failed to identify whether the resident had been offered the option of seeing a dentist. R17's admission Minimum Data Set (MDS) dated 9/24/18, identified R17 as cognitively intact, needed extensive assist with hygiene, and identified no dental concerns. R17's MDS further indicated the dental Care Area Assessment (CAA) did not trigger as being a need for comprehensive care plan. R17's care plan dated 10/3/18, indicated R17 has his own teeth with one broken tooth. R17 was to be supplied with required mouth care items. Staff were to assist to set up any necessary appointments and rides.	F 791	on meeting the requirement for timely dental, vision, and hearing appointments. Any staff members unable to attend were provided written education with a post test by the staff development nurse. To improve our process a log book was initiated on 12/29/18 that will be kept in the ward secretaries office that all requests and appointments will be logged in. The appointment will be scheduled with the residents provider of choice within 3 days of the request. Diets will be modified as needed until the resident can procure treatment for their dental issue. This is completed by sending the dietary department a "change of diet" form per our routine standing orders. The log book will be audited weekly by the Director of Nursing X 8 weeks and then monthly going forward for compliance. Written by Dawn Huelsman, RN/DON submitted by Shelby McNeil, RN per her authority.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245243	A. BUILDING _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
F 791	Continued From page 3 Review of a dental evaluation note dated 9/24/18, indicated a message was sent to the ward clerk (WC) of the facility, to arrange a dental appointment for R17. Review of R17's care conference note dated 10/1/18, failed to indicate whether there had been any follow up discussion about R17's needed dental care. During an interview with R17 on 12/4/18 at 7:33 a.m., R17 stated he had some missing teeth but denied pain or chewing difficulties. R17 expressed a desire to see the dentist and confirmed staff were aware of his wish to be seen by a dentist. During an interview with registered nurse (RN)-B on 12/4/18 at 1:08 p.m., RN-B stated she was not aware of any issues with R17's teeth or his request for a dental visit. Further interview on 12/5/18 at 11:09 a.m., with RN-B indicated she had visited with R17 about his dental concerns on 12/4/18, and had documented a note in the EHR. RN-B confirmed the WC had been given a message in September to schedule R17 for a dental appointment. RN-B said they were currently trying to determine why R17 had not had his ordered dental appointment. A progress note documented 12/5/18 at 11:00 a.m., indicated RN-B had asked R17 if he was having any problems with his teeth and R17 had denied any concern. The note also indicated RN-B has asked R17 if he wanted to see a dentist, and R17 had responded he wanted his broken tooth fixed.	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245243	A. BUILDING _____ B. WING _____	12/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANITE MANOR	250 JORDAN DRIVE GRANITE FALLS, MN 56241

(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 791	Continued From page 4 During an interview on 12/6/18 at 10:55 a.m., with the WC was unable to recall specifically why a visit had not been obtained. The WC thought it [the dental appointment] had been canceled because he had something else to do. He went to the dentist today. The facility's 11/14/17, Dental Care Oral Hygiene policy indicated all residents were to have access to ongoing routine and emergency dental services. An appointment for a routine assessment by a dentist within 90 days of admission of a resident would be arranged if their mouth appeared normal. The WC was to schedule appointments and assist with setting up transportation to and from the appointment.	F 791		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		12/28/18

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F 812	Continued From page 5 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure appropriate hand hygiene practices were implemented during 2 meal services in 2 of 2 units (A-Wing and B-wing). Findings include: During observation on 12/03/18 at 5:24 p.m., in the B-Wing dining room, dietary aide (DA)-B transported the food cart from the dietary kitchen into the kitchenette. DA-B put on gloves and prepared the serving area by placing the food containers into the steam table. She then retrieved serving spoons, opened a cabinet and removed a spool of plastic wrap. She grabbed each resident's menu card and continued to prep for the meal service by retrieving several bags of hamburger buns. With her same gloved hands, she removed a chicken breast from the steam table and placed it on a plate. She then continued to the chicken into bite sized pieces. DA-B opened the bag containing buns and placed it on the plate. DA-B then picked up bowl, scooped pork and beans into the bowl and placed the bowl on the plate. DA-B then opened a cabinet in and retrieved a plate cover. DA-B then opened a different cabinet removing a loaf of bread. DA-B opened the package and removed 2 slices of bread and placed them into the toaster. DA-B resumed serving food. That process was repeated multiple times. After she had finished, DA-B removed her gloves and washed her hands. During interview on 12/3/18 at 6:05 p.m., with DA-B indicated she should have changed her	F 812	On 12/26/18 and on 1/2/2019 Dietary staff member reviewed a video with post test of how to perform proper hand washing. On 1/3/2019 the Dietary staff will be learning a new serving procedure that will be implemented on 1/4/2019. Staff were educated on proper hand washing prior to setting up and serving food, with a return demonstration. Personal habits that must be avoided such as: touching mouth, face, hair or other parts of their body, wiping dirty hands on soiled aprons while serving food. Touching other environmental objects should be avoid or you should wash your hands after touching them include but are not limited to: wheelchairs, door handles, refrigerator doors, counters, table tops, cupboard doors/drawers. Employees were reminded that they need to avoid touching plates, silverware, drinking glasses or cups that the residents food or mouth will touch. * Sanitized and long handled utensils should be used to handle food. *Scoops, ladles, tongs, etc should be stored in the food during serving or on a clean plate or pan by the serving area. *Remove the utensils you will need prior to starting to serve the meal. Staff were also provided a list of when they need to wash their hands: *picking something off the floor *handling soiled dishes and linens *answering the telephone *using the restroom *assist a resident that requires hands on	

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F 812	Continued From page 6 gloves between tasks and before handling food. She agreed she should have performed hand hygiene and changed her gloves between tasks. Interview on 12/3/18 at at 6:08 p.m., with the dietary manager (DM) revealed her expectation was gloves should be changed and hand hygiene performed by staff between tasks to prevent cross-contamination. Observation of meal service on the A wing on 12/4/18 at 7:47 a.m., dietary aid (DA-A) put on gloves and served food to a resident at a dining table. Wearing the same gloves, DA-A assisted another residentat the same table to fill out slip of paper for the lunch meal. DA-A used a pen from the table that had been used by other residents and was in contact with soiled utensils. DA-A returned to the kitchen area, and, without removing gloves or washing hands touched the refrigerator handle, a pan on the range, and serving utensils. At 7:56 a.m., DA-A removed her gloves, washed her hands, and donned 2 pairs of gloves to each hand. DA-A cracked open an egg to fry in the pan on the range, removed the outer glove layer from her right hand, poured milk into a glass and served the meal to a resident. DA-A returned to the kitchen opened the refridgerator door, and removed her glove donned another glove and resumed serving food. During an interview on 12/4/18 at 08:14 a.m., DA-A identified gloves needed to be changed between tasks. She verivied she had not performed appropriate handwashing after removing gloves. She was the only person plating serving food during the breakfast meal. During an interview on 12/06/18 10:14 a.m. with	F 812	contact *change gloves when they become soiled, wash hands after removing gloves *hold dishes by the bottom edge, silverware by the handle *no bare hand food contact *use scoops or tongs to get ice /or use the ice dispenser *Avoid touching menus or tray cards while serving food Two dietary staff members will be serving the noon and evening meals together starting this process change on 1/4/2019. We will serve the area that does not have the salad bar first at noon and alter between the two neighborhoods. In the evening the two dietary staff members will serve one neighborhood and than serve the second neighborhood starting on Neighborhood A. This will assist the staff to maintain optimal infection control practices while servicing the residents their meals. This will be audited weekly for one month by the dietary manager and quarterly going forward by the dietary supervisor or dietary manager. A special Resident council meeting was held on 12/31/18 to update them on the changes with the serving of meals starting on 1/4/19. Created by Dawn Huelsman, RN/DON and submitted per her Authority by Shelby McNeil, RN.	

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F 812	Continued From page 7 RN-A, and the dietary manager (DM), the expectation for glove use in dietary was to wear gloves any time staff were serving and directly handling food. Staff were expected remove gloves and wash their hands between tasks. The DM identfied that appropriate handwashing was difficult during the breakfast service because dietary staff worked alone and were responsible for both plating and serving food. Both RN-A and DM verified that double gloving was not an accepted practice at the facility. Review of the facility's Handwashing policy and procedure dated 9/23/18, indicated staff were to wash hands after patient contact, after contact with body fluids, after contacte with contaminaed surfaces, contact with mucous membranes, and after contacte with inanimate objects likely to be contaminated. Additionally hand were to be washed after removing gloves. Review of the 11/14/18, Correct Use of Gloves policy indicated staff were to remove gloves when they become contaminated, before leaving the work area, and to wash hands after removing gloves.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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. §483.80(a) Infection prevention and control	F 880		12/28/18

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F 880	Continued From page 8 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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	F 880		

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F 880	Continued From page 9 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide hand hygiene and glove changes between tasks and during cares for 3 of 4 residents (R17, R29 and R39) Findings include: During observation of R39's personal care on 12/3/18 at 4:38 p.m., certified nursing assistants (CNA-A) and CNA-B assisted R39 with incontinent care. CNA-B removed R39's soiled brief, cleansed her perineal area (private area), and applied a new brief. After care, CNA-A and CNA-B removed both removed their gloves. Both CNA's put on new gloves without performing hand hygiene and continued to assist R39 with her clothing and transferred her to her Geri-chair (specialized wheelchair). CNA-B took the mechanical lift used on R39 to another room without first ensuring it had been disinfected with an appropriate chemical. CNA-A and CNA-B did	F 880	On 12/13/18 education was provided to the nursing department regarding proper infection control practices during dressing changes and during personal cares. Staff were re-educated on removing soiled gloves after completion of the soiled portion of a dressing change and or personal cares and that they should cleanse their hands prior to starting the clean portion of the dressing change and apply clean gloves. Nurse aide staff can continue with most care without donning new gloves unless they are going to be working with bodily fluids or soiled linen / trash. Nurse aide staff are annually audited for their ability to complete all routine nursing cares properly and if they have deficient practices they are re-educated on the spot by the staff development RN and also upon hire within their first 90 days of employment.	

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F 880	Continued From page 10 not perform hand hygiene after removing their gloves. During an interview with CNA-A on 12/3/18 at 4:52 p.m., she agreed hand hygiene should have been performed before and after resident care and after removing gloves. She indicated lifts were only cleaned and disinfected each night shift but not between resident use. During an interview with CNA-B on 12/3/18 at 5:00 p.m., she agreed hand hygiene should have been performed before and after resident care to prevent the potential spread of infection. Lifts were not disinfected between resident use, but were cleaned by the night shift. During an interview on 12/06/18 at 10:14 a.m., with the infection control preventionist (ICP) revealed her expectation was staff were to remove their gloves and perform hand hygiene between tasks. She was aware mechanical lifts used by multiple residents had not been disinfected between use. She agreed multiple resdient use items needed to be disinfested by staff after use. During observation on 12/3/18 at 6:40 p.m., of R17's stage 4 coccyx (tailbone area) pressure ulcer with LPN-B revealed LPN-B put on a gown and gloves and proceeded to remove the tape and strap that held the dressing in place. She removed the soiled dressing and wound packing, and proceeded to clean the wound with saline. While still wearing her soiled gloves she re-packed the wound with Dakins (specialized bleach solution) soaked gauze, covered the	F 880	Dressing changes and personal cares will be routinely audited by the Infection Control Preventionist on a monthly basis going forward within her routine infection control audits. The residents observed in the survey have not had any new infections or issues identified. Created by Dawn Huelsman, RN/DON. Submitted upon her authority by Shelby McNeil, RN	

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F 880	Continued From page 11	F 880		

wound with a clean dressing, and replaced the strap securing it with tape.

During observation of R29's G-tube dressing change on 12/4/18 at 12:37 p.m., licensed practical nurse (LPN)-B put on gloves, removed the old dressing, and cleansed the wound. While wearing her soiled gloves, she applied a clean dressing. LPN-B had not performed appropriate hand hygiene with a glove change between discarding the dressing and applying a new one.

During interview on 12/04/18 at 1:08 p.m., registered nurse (RN)-B stated any time you touch a wound then you should change your gloves. RN-B stated she personally goes through many gloves during a dressing change.

Review of the facility's Handwashing policy and procedure dated 9/23/18, indicated to wash hands after patient contact, after contact with a source of microorganisms such as body fluids and substances, mucous membranes, inanimate objects that are likely to be contaminated, and after removing gloves.

Review of the facility's Perineal Skin Care dated 6/14/18, for Incontinent Residents indicated to remove gloves after care.

Review of the facility's Correct use of Gloves dated 11/14/18, indicated to remove gloves when they become contaminated, before leaving the work area and to wash hands after removing gloves.

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	245243	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/04/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 04, 2018. At the time of this survey, Municipal Hospital & Granite Manor 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 18 Existing Health Care Occupancies. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/07/2019

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 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. Municipal Hospital & Granite Manor Nursing Home was built in 2015, and is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type V(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 48 beds and had a census of 47 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101	K 901		1/7/19

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K 901	Continued From page 2 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. The deficient practice could affect all residents. Findings include: During documentation review between 10:00 AM and 1:30 PM on 12/04/2018, documentation review and staff interview revealed the required risk assessment NFPA 99 had not been started at the time of the survey. This deficient condition was confirmed by the Facility Maintenance Supervisor.	K 901	On 1/7/2019 a Gas and Electrical Risk assessment was completed by the Director of Nursing. On 1/4/2019 a policy and procedure was implemented regarding completing an annual gas and electrical risk assessment. The director of nursing will complete this risk assessment annually and on an as needed basis related to changes in equipment in use. Date Completed: 1/7/2019 by Dawn Huelsman RN DON Submitted by Shelby McNeil, RN, per authority.	