

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 02FD F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00740

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245275 2.STATE VENDOR OR MEDICAID NO. (L2) 964043600	3. NAME AND ADDRESS OF FACILITY (L3) EDINA CARE & REHAB CENTER (L4) 6200 XERXES AVENUE SOUTH (L5) RICHFIELD, MN (L6) 55423	4. TYPE OF ACTION: <u>7</u> (L8) <div style="display: flex; justify-content: space-between;"> <div> 1. Initial 3. Termination 5. Validation 7. On-Site Visit </div> <div> 2. Recertification 4. CHOW 6. Complaint 9. Other </div> </div> 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 06/30
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 08/08/2014 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) : 12.Total Facility Beds 125 (L18) 13.Total Certified Beds 125 (L17)	10.THE FACILITY IS CERTIFIED AS: <div style="display: flex;"> <div style="flex: 1;"> X A. In Compliance With Program Requirements Compliance Based On: <u>1</u>. Acceptable POC </div> <div style="flex: 1;"> <u>And/Or Approved Waivers Of The Following Requirements:</u> <div style="display: flex; justify-content: space-between;"> <div> <u>2</u>. Technical Personnel <u>3</u>. 24 Hour RN <u>4</u>. 7-Day RN (Rural SNF) <u>5</u>. Life Safety Code </div> <div> <u>6</u>. Scope of Services Limit <u>7</u>. Medical Director <u>8</u>. Patient Room Size <u>9</u>. Beds/Room </div> </div> </div> </div> B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A* (L12)	
14. LTC CERTIFIED BED BREAKDOWN <div style="display: flex; justify-content: space-around;"> <div>18 SNF (L37)</div> <div>18/19 SNF (L38)</div> <div>19 SNF (L39)</div> <div>ICF (L42)</div> <div>IID (L43)</div> </div> <div style="text-align: center; margin-top: 10px;"> 125 </div>		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 <u>Gayle Lantto, Supervisor</u>	Date : <u>08/12/2014</u> (L19)	18. STATE SURVEY AGENCY APPROVAL <u>Anne Kleppe, Enforcement Specialist</u>
Date: <u>08/12/2014</u> (L20)		
PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY		
19. DETERMINATION OF ELIGIBILITY <input checked="" type="checkbox"/> 1. Facility is Eligible to Participate <input type="checkbox"/> 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 05/01/1985 (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) <u>VOLUNTARY</u> 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active	
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO. 03001 (L28) (L31)	30. REMARKS Posted 08/25/2014 Co.
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE 08/08/2014 (L33)	
DETERMINATION APPROVAL		



Protecting, Maintaining and Improving the Health of Minnesotans

August 12, 2014

Mr. Dennis Decosta, Administrator
Edina Care & Rehabilitation Center
6200 Xerxes Avenue South
Richfield, Minnesota 55423

RE: Project Number S5275024 and Complaint Number H5275069

Dear Mr. Decosta:

On July 9, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 26, 2014 that included an investigation of complaint number H5275069. 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 August 8, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 4, 2014 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 June 26, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 31, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 26, 2014, effective July 31, 2014 and therefore remedies outlined in our letter to you dated July 9, 2014, will not be imposed.

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

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

Sincerely,

A handwritten signature in cursive script, appearing to read "Anne Kleppe", is located below the "Sincerely," text.

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5275

August 12, 2014

Mr. Dennis Decosta, Administrator
Edina Care & Rehabilitation Center
6200 Xerxes Avenue South
Richfield, Minnesota 55423

Dear Mr. Decosta:

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 July 31, 2014 the above facility is certified for:

125 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 125 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

A handwritten signature in cursive script, appearing to read "Anne Kleppe", is located below the "Sincerely," text.

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245275	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 8/8/2014
Name of Facility EDINA CARE & REHAB CENTER		Street Address, City, State, Zip Code 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0356 Reg. # 483.30(e) LSC	Correction Completed 07/31/2014	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 07/31/2014	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By GL/AK	Date: 08/12/2014	Signature of Surveyor: 15507	Date: 08/08/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 6/26/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245275	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN BUILDING 01	(Y3) Date of Revisit 8/4/2014
Name of Facility EDINA CARE & REHAB CENTER		Street Address, City, State, Zip Code 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix _____ Reg. # NFPA 101 LSC K0144	Correction Completed 07/31/2014	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By PS/AK	Date: 08/12/2014	Signature of Surveyor: 28120	Date: 08/04/2014
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 6/24/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 02FD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00740

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5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 06/26/2014 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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	
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14. LTC CERTIFIED BED BREAKDOWN <div style="display: flex; justify-content: space-around;"> <div>18 SNF (L37)</div> <div>18/19 SNF 125 (L38)</div> <div>19 SNF (L39)</div> <div>ICF (L42)</div> <div>IID (L43)</div> </div>	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 <u>Elizabeth Nelson, HFE NE II</u>	Date : 07/21/2014 (L19)	18. STATE SURVEY AGENCY APPROVAL <u>Anne Kleppe, Enforcement Email</u> 08/06/2014 (L20)
PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY		
19. DETERMINATION OF ELIGIBILITY <div style="display: flex;"> <div style="flex: 1;"> <input type="checkbox"/> 1. Facility is Eligible to Participate <input type="checkbox"/> 2. Facility is not Eligible </div> <div style="flex: 1; text-align: right;">(L21)</div> </div>	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 : _____
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26. TERMINATION ACTION: (L30) <u>VOLUNTARY</u> 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement <u>OTHER</u> 07-Provider Status Change 00-Active	
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31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE (L33)	
DETERMINATION APPROVAL		



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5200

July 9, 2014

Mr. Dennis Decosta, Administrator
Edina Care & Rehabilitation Center
6200 Xerxes Avenue South
Richfield, Minnesota 55423

RE: Project Number S5275024

Dear Mr. Decosta:

On June 26, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the June 26, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5275069.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the June 26, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5275069 that was found to be unsubstantiated.

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

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

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

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

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

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

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gayle Lantto, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3794
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 5, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 5, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its

effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 26, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 26, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

<http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm>

Edina Care & Rehabilitation Center

July 9, 2014

Page 5

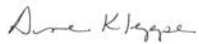
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

PRINTED: 07/09/2014
FOR MR APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/26/2014
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NAME OF PROVIDER OR SUPPLIER EDINA CARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERMES AVENUE SOUTH RICHFIELD, MN 55423
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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 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. A recertification survey was conducted and complaint investigation of H5275069 was completed and was found to be unsubstantiated.	F 000	This Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator, or any employees, agents, or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness any conclusions set forth in this allegation by the survey agency.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public	F 356	Accordingly, we are submitting the Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of Deficiencies as a condition to participate in the Medicare & Medical Assistance Programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility.	

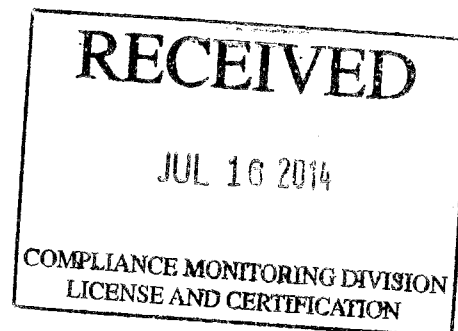
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *7/15/14*

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

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

PRINTED: 07/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/23/2014
NAME OF PROVIDER OR SUPPLIER EDINA CARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
(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 356	Continued From page 1 for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure daily nursing staffing information included the actual hours for each shift as required, potentially affecting all 103 residents residing in the facility, as visitors. Findings include: On 6/23/14, at 8:30 a.m. during the initial tour of the facility, the posting of the nurse staffing hours did not include the actual hours worked. In addition, observations on 6/24/14, and 6/25/14, revealed the posted nurse staffing hours again did not include the actual hours worked by licensed nursing staff. During an interview on 6/25/14, at 11:00 a.m. the administrator and director of nursing (DON) confirmed the staff posting did not include the actual hours worked each shift for licensed nursing staff.	F 356	F356C The staffing hours sheet has been changed on 6/26/2014 to include the hours of the shifts worked. The Staffing Coordinator was educated on using the correct staffing sheet which would include the shifts as well as the staffing hours daily. The revised staffing hours posting will be posted daily at the at the resident right to know information board. Audits will be completed to ensure the posting continues to include the staffing hours. Monitoring the daily staffing hours will be done by the Staffing Coordinator/designee and the results will be reported to the QA Committee monthly for 3 months. The facility will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the standard indicated by 6-26-14. The DNS is responsible to ensure compliance.		7-31-14
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441			



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/26/2014
NAME OF PROVIDER OR SUPPLIER EDINA CARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
(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 441	<p>Continued From page 2 of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a glucometer was properly sanitized during blood sugar observations for 1 of 1 resident (R14) and having</p>	F 441	<p>F441E Residents # R14 and R79 in this statement of deficiency have been clinically reassessed. All residents on nebulizer treatments have been reassessed. All nurses have been educated on the facility policy for cleaning of the blood glucose machines and the nebulizer equipment. Audits will be completed by the DON or designee to ensure compliance with the policy for cleaning nebulizers and blood glucose machines. Upon completion of the audits, corrective action, if applicable, will be completed immediately. The results of the audits will be reported to the QA committee monthly for 3 months. The DNS is responsible to ensure compliance.</p>		7-31-14

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245375	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2014
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NAME OF PROVIDER OR SUPPLIER

EDINA CARE & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

6200 XERMES AVENUE SOUTH
RICHFIELD, MN 55423

(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 441	<p>Continued From page 3</p> <p>the potential to affect three additional residents who received glucose testing with the shared glucometer and failed to properly clean nebulizer equipment for for 1 of 1 resident (R79) observed to receive a nebulizer treatment.</p> <p>Findings include:</p> <p>R14's blood sugar testing was observed on 6/24/14, at 6:25 p.m. A licensed practical nurse (LPN)-A donned gloves and asked the resident, "Which finger do you want?" After the testing was completed, LPN-A removed the gloves and placed the glucometer in the tote, and washed her hands. LPN-A then donned gloves and wiped the glucometer with a germicidal wipe for approximately 15 seconds.</p> <p>R79 was observed to receive a nebulizer (machine that changes liquid medication to a mist so it can be breathed directly into the lungs) treatment utilizing a face mask on 6/24/14, at 7:12 p.m. LPN-A started the nebulizer treatment and remained in the room with the resident until the treatment was finished. At 7:25 p.m. R79 finished the nebulizer treatment, LPN-A disconnected the nebulizer from the tubing and brought the nebulizer and mask into the bathroom and rinsed all parts with tap water, and used hand soap to clean the inside surface of the face mask. LPN-A then dried all pieces with paper towel and reconnected unit and returned it to resident's bedside table.</p> <p>When interviewed on 6/26/14, at 7:50 a.m. licensed practical nurse (LPN)-B who was responsible for the facility's infection control program, indicated the staff person had not followed facility policy in regards to cleaning both</p>	F 441		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245275	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/12/2014
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NAME OF PROVIDER OR SUPPLIER

EDINA CARE & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

6200 HERKES AVENUE SOUTH
RICHFIELD, MN 55423

(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 441	<p>Continued From page 4</p> <p>the shared glucometer or nebulizer for R79.</p> <p>The facility's 3/20/12 policy, Disinfecting Blood Glucose Meters directed staff to wipe all surfaces of the glucometer ensuring the device remained wet for two minutes to ensure it was effective against tuberculosis, bacterial and viral organisms. Staff was to "wrap the glucometer with germicidal wipe to ensure adequate disinfecting." The germicidal wipe (PSS Select Disinfectant) manufacturer container directed cleaning shared devices for two minutes to ensure cleaning was effective against tuberculosis, bacterial and viral organisms.</p> <p>The facility 2006, policy Nebulizer directed staff to clean nebulizer by disconnecting the nebulizer from the tubing, rinse under hot tap water to remove any residual after each use, air dry parts on clean paper towel.</p>	F 441		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245275	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2014
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NAME OF PROVIDER OR SUPPLIER

EDINA CARE & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
6200 XERXES AVENUE SOUTH
RICHFIELD, MN 55423

(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 000

INITIAL COMMENTS

K 000

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR
ALLEGATION OF COMPLIANCE UPON THE
DEPARTMENT'S ACCEPTANCE. YOUR
SIGNATURE AT THE BOTTOM OF THE FIRST
PAGE OF THE CMS-2567 WILL BE USED AS
VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN
ON-SITE REVISIT OF YOUR FACILITY MAY BE
CONDUCTED TO VALIDATE THAT
SUBSTANTIAL COMPLIANCE WITH THE
REGULATIONS HAS BEEN ATTAINED IN
ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the
Minnesota Department of Public Safety. At the
time of this survey, Edina Care Center was found
not in substantial compliance with the
requirements for participation in
Medicare/Medicaid at 42 CFR, Subpart
483.70(a), Life Safety from Fire, and the 2000
edition of National Fire Protection Association
(NFPA) Standard 101, Life Safety Code (LSC),
Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF
CORRECTION FOR THE FIRE SAFETY
DEFICIENCIES (K-TAGS) TO:

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:

POC ok
PS 7-21-14



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

TITLE

(X6) DATE

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245275	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/24/2014
NAME OF PROVIDER OR SUPPLIER EDINA CARE & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 3-story building was determined to be of Type II (222) construction. It has a full basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 125 beds and had a census of 103 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD	K 000			
K 144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	Facility has adopted "Weekly Generator Inspection" template from the State Fire Marshall website-attached. The Maintenance Director will be responsible for the weekly generator inspection. Copies of the weekly generator inspections will be provided to the Quality Assurance Committee for the duration of 3 months.	7-31-14	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245275	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/24/2014
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NAME OF PROVIDER OR SUPPLIER EDINA CARE & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6200 XERXES AVENUE SOUTH RICHFIELD, MN 55423
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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
K 144	<p>Continued From page 2</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility's emergency generators do not comply with NFPA 99 Health Care Facilities (1999 edition) nor NFPA 110 Standard for Standby Power Systems (1998 edition). This deficient practice could affect all patients.</p> <p>Findings include:</p> <p>On facility tour between 9:30 AM and 12:00 PM on 06/24/2014, record review revealed that there was no documentation of the weekly generator inspections for calendar year 2014.</p> <p>This deficient practice was verified by the Maintenance Director at the time of the inspection.</p>	K 144		

Edina Care Center

Emergency Generator – Weekly Inspection Checklist

[illegible]