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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 0TKB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00109

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245465**
2.STATE VENDOR OR MEDICAID NO.
(L2) **668340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COMMUNITY MEMORIAL HOME**
(L4) **410 WEST MAIN STREET**
(L5) **OSAKIS, MN** (L6) **56360**

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 **04/02/2012** (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Marge Meeker, Unit Supervisor 04/02/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege,Program Specialist 06/01/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
~~VOLUNTARY~~ ~~00~~
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
~~INVOLUNTARY~~
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
~~OTHER~~
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
03/30/2012 (L33)

DETERMINATION APPROVAL

CCN: 24-5465

Item 16 Continuation for CMS-1539

An abbreviated standard survey was completed at this facility on March 6, 2012. Deficiencies were found, the most serious deficiencies were isolated deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D).

On April 26, 2012 a standard survey, was conducted and deficiencies, the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F).

Since the facility was not found in substantial compliance at the time of the standard survey, we recommended the following to the CMS RO:

- Mandatory DOPNA, effective April 26, 2012

On March 16, 2012, the Minnesota Department of Health and the Office of Health Facility Complaints completed a Post Certification Revisit (PCR), and on April 2, 2012, the Minnesota Department of Public Safety completed a PCR. Based on the PCR's it was determined that the facility had achieved substantial compliance pursuant to the standard survey completed on March 6, 2012, and standard survey completed April 26, 2012, effective March 16, 2012. As a result, we recommended the following to the CMS RO:

- Mandatory DOPNA, effective April 26, 2012 be rescinded

See attached CMS-2567B for the results of the March 16, 2012 and April 2, 2012 revisits.

Documentation supporting the facility's request for a continuing waiver involving K067 was previously forwarded. Approval of the waiver request was recommended.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5465

June 1, 2012

Mr. David Carlson, Administrator
Community Memorial Home
410 West Main Street
Osakis, Minnesota 56360

Dear Mr. Carlson:

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 March 16, 2012 the above facility is recommended for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K67. If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency or renew your request for waiver in order to continue your participation in the Medicare Program.

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

Sincerely,

Nicole Steege

Nicole Steege, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone #: (651) 201-4124 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 2, 2012

Mr. David Carlson, Administrator
Community Memorial Home
410 West Main Street
Osakis, Minnesota 56360

RE: Project Number S5465022 & H5465007

Dear Mr. Carlson:

On February 9, 2012, we informed you that the following enforcement remedy was being recommended:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 26, 2012. (42 CFR 488.417 (b))

This was based on the deficiencies cited by the Minnesota Department of Health, Office of Health Facility Complaints for an abbreviated standard survey completed on January 30, 2012, that found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), and the lack of information from the standard survey completed on January 30, 2012. The most serious deficiencies at the time of the standard survey were found 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 March 16, 2012, Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) and on April 2, 2012, the Minnesota Departments of Health and Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey and standard survey completed on January 30, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 16, 2012. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on January 30, 2012, as of March 16, 2012.

As a result of the revisit findings, the Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of February 9, 2012:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 30, 2012, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective April 30, 2012, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective April 30, 2012, is to be rescinded.

In our letter of February 9, 2012, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 30, 2012, due to denial of payment for new admissions. Since your facility attained substantial compliance on March 16, 2012, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Your request for a continuing waiver involving the deficiency(ies) cited under K67 at the time of the January 30, 2012 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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,

Marge Meeker

Marge Meeker, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7317 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File 5465R12.RTF

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245465	A. Building B. Wing	3/16/2012

Name of Facility	Street Address, City, State, Zip Code
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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 **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **03/16/2012**	ID Prefix **F0165** Reg. # **483.10(f)(1)** LSC	Correction Completed **03/16/2012**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/16/2012**
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **03/16/2012**	ID Prefix **F0249** Reg. # **483.15(f)(2)** LSC	Correction Completed **03/16/2012**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **03/16/2012**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **03/16/2012**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **03/16/2012**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/16/2012**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/16/2012**	ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **03/16/2012**	ID Prefix **F0492** Reg. # **483.75(b)** LSC	Correction Completed **03/16/2012**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/SNL	04/02/2012	03020	03/16/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/26/2012			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245465	01 - MAIN BUILDING 01	4/2/2012

Name of Facility	Street Address, City, State, Zip Code
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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 03/12/2012	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	Date:	Signature of Surveyor:	Date:
	PS/SNL	04/02/2012	27200	04/02/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/30/2012			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245465	A. Building B. Wing 02 - 2 BLDG PT/OT WELLNESS CENTER	4/2/2012

Name of Facility	Street Address, City, State, Zip Code
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0144	03/12/2012	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/SNL	Date: 04/02/2012	Signature of Surveyor: 27200	Date: 04/02/2012
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/30/2012		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: 0TKB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00109

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245465**

2.STATE VENDOR OR MEDICAID NO.
(L2) **668340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COMMUNITY MEMORIAL HOME**
(L4) **410 WEST MAIN STREET**
(L5) **OSAKIS, MN** (L6) **56360**

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 **01/30/2012** (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 IMR	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** ,5 (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	52			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jonathan Hill, HFE NE II 03/23/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Susan N. Leppke, Program Specialist 03/30/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 3/30/2012 ML
AW LSC K67 in ACO. 04/02/2012 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

At the time of the abbreviated standard survey completed on January 30, 2012, the facility was not in substantial compliance and the most serious deficiencies were isolated that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On January 26, 2012, the Minnesota Department of Health and on January 30, 2012, the Minnesota Department of Public Safety completed a standard survey 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 were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required.

The Department recommended the following enforcement remedies for imposition to the Center for Medicare and Medicaid Services (CMS) Region V Office:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective April 30, 2012. (42 CFR 488.417 (b))

The facility will be subject to loss of Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs (NATCEP) for two years.

See attached CMS-2567 for survey results. Post Certification Revisit to follow.

The facility's request for a continuing waiver involving the deficiency cited at K67 is recommended for approval. Documentation supporting the waiver request is attached.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 4839

February 9, 2012

Mr. David Carlson, Administrator
Community Memorial Home
410 West Main Street
Osakis, Minnesota 56360

RE: Project Number S5465022 and H5465007

Dear Mr. Carlson:

On February 2, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on January 30, 2012 . This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On January 26, 2012, the Minnesota Department of Health and on January 30, 2012, the Minnesota Department of Public Safety completed a standard survey 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 to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective April 30, 2012. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective April 30, 2012. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 30, 2012. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Community Memorial Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective April 30, 2012. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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:

Pat Halverson
Minnesota Department of Health
Government Service Center
320 West Second St, Room 703
Duluth, Minnesota 55802-1402

Telephone: (218) 723-4637
Fax: (218) 723-4920

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 remedy be imposed:

• 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 July 30, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 723-4637 Fax: (218) 723-4920

Enclosure

cc: Licensing and Certification File

5465s12.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING _____ B. WING _____ RECEIVED FEB 2 2012 MN Dept of Health	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(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 PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. Census at the time of survey was 42.	F 000	Ok & addendum page 23 3/2/12 RH	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157	F157 Failure to notify the physician for low blood pressure.. The physician assessed R47 on 2/22/2012 at a routine visit. The physician reviewed the vital signs and medications and addressed any condition changes. The pharmacy consultant reviewed medication regimen on 2/13/2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David E. Carlson,	Administrator	2-23-12

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

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F 157	Continued From page 1 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician for low blood pressures for 2 of 2 residents (R47, R53) in the sample reviewed for blood pressures. Findings include: R47's diagnosis included essential hypertension (high blood pressure). R47 received hydrochlorothiazide (medication used to treat high blood pressure and fluid retention) 50 milligrams (mg) every day. A review of R47's blood pressures indicated the following low blood pressures: On 5/18/12, R47's blood pressure was 106/46 (a normal blood pressure is 120/80). On 8/31/12, R47's blood pressure was 120/40. On 11/23/11, R47's blood pressure was 110/20. The progress notes for 5/18/11, 8/31/11, and	F 157	The physician evaluated R53 on 1/31/2012. The physician reviewed the vital signs and medications and addressed any condition changes. The pharmacy consultant reviewed medication regimen on 2/13/2012. To ensure that other residents are not affected by this deficient practice, a blood pressure check and review policy will be developed and implemented on 3/5/2012. To ensure that this deficient practice does not reoccur, the licensed staff will review and enter the vital signs in to the computer. The physician will be notified if the resident is symptomatic of decreased or elevated blood pressure.	

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F 157	Continued From page 2 11/23/11 lacked documentation of physician notification. At 11:08 a.m. on 1/26/12, the director of nursing (DON) was interviewed and stated she would expect nurses to recheck low blood pressures, document in the progress notes, and notify the physician. DON verified she was not aware of the low blood pressures, and the physician was not notified. On 1/15/12, R53 experienced a blood pressure of 80/42 with symptoms of hypotension (low blood pressure) and the physician was not notified. R53 had diagnoses to include hypertension (HTN), aortic valve disorders, coronary artery disease (CAD), history of an acute myocardial infarction (MI) and edema. R53's signed physician's orders dated 1/5/12, indicated he received the following medications: Lasix 40 mg by mouth (PO) daily for the diagnosis of edema; Lisinopril 2.5 mg PO Daily for diagnosis of HTN; Imdur 30 mg PO daily for diagnosis of angina; Hytrin 10 mg PO Daily at bedtime for diagnosis of benign prostate hypertrophy (BPH); Mirapex 0.5 mg PO six times per day (every 4 hours) around the clock and Sinemet CR 25/100 PO six times daily (every 4 hours before Mirapex) around the clock for diagnosis of Parkinson's. All medications had the potential listed side effect of hypotension. On 1/15/12, a nursing progress note indicated R53 was sitting in the bed and observed to be "pale," stated he was "light headed," and had a blood pressure (BP) of 80/42 with respirations of 22. The note further indicated an antacid was	F 157	The DON or her delegate will perform 3 random audits weekly for twelve weeks to evaluate resident blood pressures and if necessary follow-up was completed for symptomatic blood pressures. The above deficiency will be reviewed at the next Quality Assurance Meeting, which is tentatively scheduled for 3/20/2012. During the review, the corrective actions put into place along with any audits and their results will also be discussed among the attendees. The licensed nursing staff will be educated on the blood pressure check and review policy at a nurses meeting tentatively scheduled on 2/29/2012. The corrective action will be completed on or by 3/5/2012.	03/05/2012

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F 157	Continued From page 3 administered, the foot of the bed was elevated and the BP was rechecked (no specific amount of time after first BP) and found to be 86/50 with the feet elevated in the bed. The note indicated R53's son was present at the time of the low BP. The clinical record lacked evidence the physician was notified of the hypotensive episode. At 1:14 p.m. on 1/25/12, the licensed practical nurse (LPN-E) stated blood pressures that were low and with symptoms of hypotension should be reported to the physician. LPN-E confirmed the 1/15/12 blood pressure should have been reported to the physician. At 2:39 p.m. on 1/26/12, DON stated she would expect the BP to be rechecked if found to be low. DON reviewed the note for the low BP's and confirmed the low BP. "I would expect that the LPN would do a recheck on that BP within 15 minutes and if it remains low, the MD should be updated." The DON confirmed the BP was not rechecked after BP remained low when the foot of the bed was elevated. At 3:22 p.m. the case manager (CM-B) further confirmed the physician was not notified of the low blood pressure. The facility policy and procedure on notification of change dated 12/17/07, directed the physician be notified of significant changes in the resident's condition by a registered nurse (RN). If an RN is not available, the licensed practical nurse (LPN) should call the DON for questions or suggestions.	F 157		
F 165 SS=D	483.10(f)(1) RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL A resident has a right to voice grievances without discrimination or reprisal. Such grievances	F 165	F 165- Failure to follow up on resident grievance	

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F 165	Continued From page 4 include those with respect to treatment which has been furnished as well as that which has not been furnished. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure grievances voiced by 1 of 1 resident (R78) in the sample, were acted upon. Findings include: R78 had diagnoses that included a hip fracture and osteoarthritis. The admission minimum data set (MDS) dated 1/10/12, indicated R78's hearing was adequate, her vision was adequate with glasses and her speech was clear. R78's cognition was intact and there were no behavioral concerns. R78 was cognitively intact. The vulnerability care plan dated 1/9/12, identified R78 was alert and able to communicate her needs. During an interview at 6:52 p.m. on 1/23/12 , R78 stated one of the therapy staff was rude to one of her guests. R78 stated she reported the incident to the activity director (AD) today. R78 stated she was not afraid. At 10:30 a.m. on 1/25/12, the AD stated R78 reported that a physical therapy aid (PTA) was rude to R78's guest. The AD reported the incident to registered nurse (RN)-B and to the physical therapy manager.	F 165	Licensed Social Worker followed up with resident #78 upon notification of grievance on 1/25/12. A grievance report was filed that same day. The therapy supervisor was also notified and reported that she would be discussing this incident with the therapy staff member involved. The incident was reviewed with resident #78 who admitted that although she had not been mistreated herself, she was glad that the incident was being reviewed with the staff member involved. No other concerns were voiced by the resident. Discussion between the DON, and AD (Activity Directory) was held on 1/25/12 to discuss if any other grievances had been reported by other residents. No other residents had voiced grievances to AD. The AD was informed of the grievance policy and was shown the binder in the DON office which contained filed grievances along with a review of the basic grievance form. Staff were educated on 1/27 and 2/2/12 staff meetings by the DON on grievance policy. Prior to 2/3/12, the DON and LSW had the only access to the grievance forms. To make these more accessible to staff throughout the facility, copies of the grievance form were made and distributed to the case managers, AD, and nurses' station on 2/3/12. Staff were informed at the meetings that the forms would be available at these locations.	

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F 165	Continued From page 5 RN-B, interviewed at 10:50 a.m. on 1/25/12, stated the incident could have been reported as a potential resident grievance but she didn't think of it. During an interview with the social worker (SW) at 1:28 p.m. on 1/25/12, the SW indicated she spoke with R78 regarding the staff person being rude to her. R78 told the SW that it was directed toward her guest so the SW would file a grievance regarding the guest. The director of nursing (DON), interviewed on 1/26/12 at 1:19 p.m., stated the concern should have been written on a grievance/complaint form at the time of the report. The facility's Resident and Tenant Concern and Grievance Procedure, revised on 7/13/09, indicated the purpose was to ensure that complaints were received and resolved in a prompt, reasonable and satisfactory manner for residents and tenants and to assure continued improvements in the delivery of services to them. The procedure indicated that, upon entering into a service/admission agreement, all clients will be notified in writing of their right to complain to their provider about services received. The policy directed residents to direct their concerns to the appropriate supervisor from a list on the form. The list included the AD.	F 165	During the weekly Risk Meetings, the DON or her delegate will audit grievance reports. This will be done by reviewing any grievances filed that week, and conduct a survey with attendees if any other reports were made/reported that could have been missed and undocumented. The audits will continue weekly for one quarter to assure that grievances are being filed and corrective action has taken place. The above deficiency will be reviewed at the next quality assurance meeting which is tentatively scheduled for March 20, 2012. During the review, the corrective actions put into place along with any audits will be discussed among the attendees. Changes can be made to the action plan as needed after this review and discussion has taken place. Corrective action was accomplished on 2/3/2012 for this deficiency.	02/03/2012
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	F226 Failure to ensure that the abuse prevention policy correctly reflected the federal data.	

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F 226	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure the abuse prevention policy correctly reflected the required federal data. Findings include: The facility Vulnerable Adult Policy and Procedure/Prevention Plan, revised on 8/11, lacked the definition of injuries of unknown source and lacked direction for immediate notification to the state agency for incidents of potential mistreatment. The policy directed initial reports of abuse, neglect, misappropriation of resident property and financial exploitation to the administrator, common entry point (CEP) and the office of health complaints (OHFC) within 24 hours. The policy did not direct staff to report immediately as required by federal regulation. The policy indicated that verbal or physical aggression between two residents was not reportable unless it caused serious harm. The federal regulation directed reporting of all resident to resident altercations. The policy stated that unexpected occurrences or accidents that were an individual's single mistake, were generally not reportable. The director of nurses (DON), interviewed on 1/26/23 at 1:19 p.m. verified the policy did not include the required direction in regard to immediate reporting, the definition of injuries of	F 226	There were no residents affected by the deficient practice. To correct this deficiency the facility updated the abuse prevention policy to include the federal requirements. Direct care staff were educated regarding the revisions on 1/27/2012 and licensed staff was educated regarding the revisions on 2/02/2012. All staff will be educated on the revisions at the next all staff meeting on 3/9/2012. The above deficiency will be reviewed at the next Quality Assurance Meeting, which is tentatively scheduled for 3/20/2012. During the review, the corrective actions put into place along with any audits and their results will also be discussed among the attendees. The corrective action was completed on 2/3/2012.	02/03/2012

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F 226	Continued From page 7 unknown source or resident to resident altercations.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not provide timely response to call lights for 1 of 1 residents (R78) in the sample. Findings include: R78 was incontinent of urine because her call light was not answered timely. R78 had diagnoses that included a hip fracture and osteoarthritis. The admission minimum data set (MDS) dated 1/10/12, indicated R78's hearing was adequate, her vision was adequate with glasses and her speech was clear. R78's cognition was intact and there were no behavioral concerns. R78 transferred and used the toilet with extensive assistance of one staff and was occasionally incontinent of urine. The toileting care plan dated 12/28/11, indicated R78 required assistance for toileting and urinary continence related to impaired mobility due to recent left hip surgery. The care plan directed to	F 241	F- 241 Failure to respond timely to resident call light Upon notification of resident #78 complaint of call light response time, the DON reviewed call log record for the time in question. Although the time and date resident had reported was unable to be confirmed with review of log records, all staff were informed of potential incident along with review of call times as stated in the deficiency report. The resident had not reported this incident to staff and was encouraged if any further episodes of untimely answered call lights occur, to report it to supervising nurses to follow up can be completed. Concerns regarding timely answering of call lights are reviewed during each resident council meeting as a way to allow residents to share any concerns. No concerns regarding call light response times were reported at the last resident council meetings per review of notes. No concerns reported by staff of other resident complaints of call light response times. If concerns are brought forward, the DON reviews the call log for verification of call light times. Only direct nursing staff along with floor charge nurses had previously carried nursing pagers which receive call light alerts. The DON ordered pagers for RN supervisors, RN Case Managers, and the Director of Nursing on 2/3/2012 which arrived and were connected to the paging system on 2/6/2012. This will allow extra staff to be alerted to unanswered call lights. The Director of Nursing also reviewed the importance of timely answering of pages at both staff meetings with were held on 1/27 and 2/2/2012. Staff have also been instructed to file grievance forms if residents report untimely answered call lights. This will assure complaints can be followed upon quickly.	

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F 241	Continued From page 8 offer and assist R78 with toileting every two hours, with rounds at night and as needed per her request. R78 used the call light appropriately with needs and did not use incontinent products. R78, interviewed at 6:57 p.m. on 1/23/12, stated that, about two weeks ago at about 3:00 a.m., they put on the call light on to go to the bathroom. No one came for an hour and R78 had to urinate in the bed. On 1/26/12, at 1:19 p.m., the director of nursing (DON) stated that residents should not have to wait more than 10 minutes for a call light response. At 1:54 p.m. the computerized call light log was reviewed with the DON and indicated the following: On 1/3/12 at 2:46 a.m., R78's call light was on for 22 minutes, and at 4:22 a.m., R78's call light was on for 16 minutes. At 5:47 pm, R78's call light was on for 50 minutes. On 1/5/12 at 1:27 p.m., R78's call light was on for 21 minutes. The DON verified the time recorded as the facility was unable to print out the record. The DON stated the call light log was reviewed when there was a resident issue or complaint. The DON was not previously aware of R78's complaint of slow call light response.	F 241	Call light audits will be conducted weekly for one month. Audits will capture call lights that may have been on in an excess of duration. Follow up by the DON or her delegate will be conducted on call lights that have been on an excess amount of time. Discipline, education, or further action will be completed pending audit results. This deficiency along with audit results will be discussed at the next Quality Assurance meeting. Corrective action for this deficiency was completed on 2/6/2012.	02/06/2012
F 249 SS=C	483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation	F 249	F249 Failure to ensure the activity director had proper credentials. The activities department will delegate Evie Akervik as the Activities consultant until the acting activities director has 1 year of full-time experience in activities.	

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F 249	Continued From page 9 specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the activity director had proper credentials. This had the potential to affect all 42 residents currently residing in the facility. Findings include: The activities director (AD-A), lacked the credentials required to be an activities director. At 12:07 p.m. on 1/25/12, AD-A was interviewed, and stated he held a bachelor's degree in athletic training and fitness and a master's degree in athletic administration. AD-A further stated he started working part time with the activities department in 1/11, became the activities director in 1/12, had no previous experience long term care activity programs prior to 1/11, and currently works between the facility and an adjoining wellness center. AD-A verified he lacked the proper credentials. At 8:32 a.m. on 1/26/12, the administrator (A-A) was interviewed and verified the activities director	F 249	To ensure that this deficient practice does not reoccur the facility will ensure that the future Activity Director has the proper credentials before able to oversee the department. When advertising and/or interviewing for the position required credentials will be included on the job requirements and the administration will ensure that these requirements are met before hire. To ensure that this corrective action is sustainable, there will be a quarterly meeting between the Activities Director and the Activities consultant to assess past activity calendars and resident council meeting minutes, as well as make recommendations for improvement and sustainability of activities program as it relates to the corrective action. The consultant and Activity Director will meet and consult on the job as needed. The above deficiency will be reviewed at the next Quality Assurance Meeting, which is tentatively scheduled for 3/20/2012. During the review, the corrective actions put into place along with any audits and their results will also be discussed among the attendees. The corrective action will be completed and put into place on 2/16/2012.	02/16/2012

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F 249	Continued From page 10 lacked the proper credentials.	F 249		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure the floors in resident rooms were kept free of wax build-up and debris on 2 of 3 facility units (the East & West units). Findings include: The floors of four resident rooms on the East unit and eleven resident rooms on the West unit, were observed to have a heavy build up of wax and brownish gray debris in front of the closet and in the corners of the room. During the tour of the environment beginning at 1:24 p.m. on 1/25/12, with the maintenance director present throughout the entire tour, the following was observed: On the East unit, resident rooms 103, 105, 108 and 109 were observed to have a heavy build up of wax and debris in front of the closet and in the corners of the room. On the West unit, resident rooms 301, 302, 303, 304, 305, 306, 307, 308, 309, 310 & 313 were observed to have a heavy build up of wax and debris in front of the closet and in the corners of the room. At 2:07 p.m. the maintenance director was unclear when the identified rooms on the 100 and 300 units were last stripped and waxed. The maintenance director stated the rooms are	F 253	F253- Failure to ensure that floors in resident rooms were kept free of wax build-up and debris. Maintenance staff will be removing wax build-up and debris from resident rooms listed in the deficiency on East and West units starting on 2/20/2012. The maintenance staff will complete 6 resident rooms a week. The resident rooms listed on the deficiency will be cleared of wax build-up and debris by 3/8/2012. Maintenance staff will be removing wax build-up and debris from the remaining resident rooms on the East and West units. The maintenance staff will complete 6 resident rooms a week, completing them by 3/15/2012.	3/8/12

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F 253	Continued From page 11 cleaned daily, but the stripping and waxing to remove the build-up and debris was done annually for "spring cleaning." The director confirmed stripping and cleaning the floors annually was not frequent enough to ensure the floors remained free of wax build-up. At 2:50 p.m. the maintenance director provided a copy of the "Quarterly Maintenance Schedule for Doors, Handrails, Registers, Water Fountains, and Door Frames" The form consisted of a list of quarterly dates and a column for each unit. In each box was a "check mark." The maintenance director stated the check meant the unit was checked by staff and meant everything "should be fine and repaired if needed." At 9:17 a.m. on 1/26/12, the administrator confirmed the findings on the 300 hall and stated the debris and wax build up would be removed on spring cleaning. The Administrator was unclear of when the build-up occurred and stated the facility had "no complaints from residents" about the cleanliness of the floors. Review of the facility's undated "Cleaning and maintenance policy for CMH (Community Memorial Home) resident rooms" policy and procedure indicated all resident rooms would be emptied out for annual maintenance, annually stripped and waxed. The policy indicated resident rooms would also be cleaned daily and any additional maintenance needed observed by staff would be done on maintenance request forms.	F 253	There will be a policy developed 3/16/2012 regarding the upkeep and maintenance of the facility flooring. The maintenance/housekeeping staff will monitor the facility floors quarterly to ensure floors are in appropriate condition. To assure that this correction is sustainable, the Director of Environmental Services or his delegate will audit the floors bi-annually to ensure that they are free of wax build-up and debris. The above deficiency will be reviewed at the next Quality Assurance Meeting, which is tentatively scheduled for 3/20/2012. During the review, the corrective actions put into place along with any audits and their results will also be discussed among the attendees. The corrective action for this deficiency will be completed by 3/8/2012.	03/08/2012
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of	F 312	F312 ADL Care/Failure to address denture use	

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F 312	Continued From page 12 daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure denture use was addressed for 1 of 2 resident (R6) in the sample, reviewed for dental needs. Findings included: During observation on 1/23/12, from 5:30 p.m. to 6:32 p.m., R6 did not have an upper denture in mouth during the supper meal. On 1/24/12 at 8:00 am, R6 was not wearing an upper denture. On 1/25/12, R6 was observed in the morning not to have her upper dentures in her mouth. The annual Minimum Data Set (MDS) dated 12/10/11, indicated R6 had severe cognitive impairment. The MDS indicated R6 wore full upper dentures intermittently depending on mood and had no chewing problems. The nutritional section of the MDS indicated that R6 had chewing problems and was on a mechanical soft diet. The dentist note dated 7/8/11, indicated R6's upper denture had been repaired. The care plan, revised 7/18/11, indicated R6 required daily assistance for cleaning her teeth and wore an upper denture, depending on mood. Staff were to encourage R6 to wear the upper denture for meals.	F 312	Resident #6 had upper dentures sent if for repair on 1/27/2012. Upper denture was returned back to resident in functional and repaired working order on 1/31/2012. After repaired denture was returned to resident, she continued to refuse to wear it routinely. The denture was found many times in the bottom of her purse or on the floor, etc. Due to her misuse and care of upper plate, denture was found broken in her purse on 2/13/2012. Family member has been updated and will be talking to resident #6 to see if she really wants them repaired again. Updated Oral assessment and Care plan will be completed pending family and resident decision. All residents receive annual oral assessments or prn with oral changes. Oral dental visits/requirements are discussed routinely during care conferences. To assure that all residents with dentures in facility have functional, correct fitting and intact dentures, a licensed staff member will audit all residents with dentures/partials by 2/27/2012. If any residents are found to have a problem with their partial/dentures, an effort will be made in getting the problems repaired or reviewed with family/resident for their preference on repairing. If any changes are needed in a resident's plan of care related to oral status, an updated Oral Assessment will be completed. Direct care staff had not updated licensed nursing that resident had broken dentures. Direct care staff thought that resident not longer wore her dentures and had not checked Kardex to assure that this assumption was correct. To make sure that direct care staff are providing care according to each resident's care plan, the resident Kardex was printed off and placed in each resident's bathroom wall cabinet on2/10/2012. This will prevent miscommunication and give the direct care staff a more readily available care guide to follow. Direct care staff were informed on the 1/27/2012 staff meeting that they are to review Kardex prior to providing cares to residents and are to update licensed staff if the kardex is not current or if referrals repairs need to be made to equipment, assistive devices, etc.	

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F 312	Continued From page 13 Nursing assistant (NA)-E, interviewed on 1/25/12, at 7:30 a.m. and 9:30 a.m., stated that she had cleaned R6 mouth with a toothette that morning. NA-E stated that R6 had not worn the upper denture for over a year. NA-F, interviewed on 1/26/12, at 10:40 a.m., stated that R6 had dentures but refused to wear them. Interview and observation with the director of nurses (DON) on 1/26/12 at 9:25 a.m., indicated R6's upper denture was in the denture cup in the medicine cabinet. NM-A, interviewed on 1/26/12, at approximately 10:30 a.m., stated staff should attempt to put in R6's uppers dentures before meals. NM-A found the upper denture was broken with sharp edges and could not be worn.	F 312	An audit will be completed on all residents in the facility with partials or dentures by 2/29/2012 by licensed staff. This deficiency along with audit results will be reviewed at the next scheduled Quarterly Assurance meeting. See addendum page 23 Correction for this tag will be completed by 2/29/2012.	3/2/12 ECH 02/29/2012
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility did not investigate circumstances surrounding a fall from a standing lift for 1 of 3 residents (R36) in the sample reviewed for falls.	F 323	F323 Failure to investigate circumstances regarding a fall. R36 will have a fall assessment completed by 2/28/2012. To ensure that other residents will not be affected by this deficient practice, the interdisciplinary team will meet weekly starting on 3/6/2012 for a risk management meeting to analyze trends involving incidence of falls.	

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F 323	Continued From page 14 Findings include: R36 fell from a standing lift; however, the incident was not thoroughly investigated to determine causative factors to reduce the risk of further problems with the lift and/or procedure. The fall risk assessment dated 12/6/11, indicated R36 was alert and able to make his needs known, had poor balance and required occasional use of a standing lift for transfers. The care plan revised on 1/19/11, indicated R36 needed transfer assistance of 1 to 2 staff and a transfer belt, and a standing lift when R36 was weak. The Incident report dated 1/3/12, and revised on 1/4/11, indicated R36 was lowered to the floor during a transfer by one staff using a standing lift. The incident report indicted R36 let go of handles during the transfer and was lowered to floor with assist of two staff. R36 sustained abrasions on both knees. The incident report indicated that the standing lift had been utilized properly but did not include evidence of an investigation into causative factors. The licensed practical nurse (LPN)-A who assessed R36 for injuries following the incident, was interviewed on 1/26/12 at 11:00 a.m., and stated she was unsure of R36's position when she arrived to help. LPN-A did not know which standing lift was used but it was one of the two lifts in the hall. On inspection LPN-A said the leg strap might have come loose, but she did not ask the nursing assistant about that at the time of the fall. LPN-A did not inspect the standing lift to determine if there were problems with the lift, sling or safety straps.	F 323	To ensure that this deficiency does not reoccur, the facility will develop and implement a post fall analysis guide. The facility will review and update the current resident incident and accident policy by 2/29/2012. To ensure that the corrective action is sustainable the DON or her delegate will complete a weekly audit for twelve weeks to verify that post fall analysis forms have been completed. The above deficiency will be reviewed at the next Quality Assurance Meeting, which is tentatively scheduled for 3/20/2012. During the review, the corrective actions put into place along with any audits and their results will also be discussed among the attendees. The licensed nursing staff will be educated on the policy regarding the post fall analysis form at a nurses meeting tentatively scheduled on 2/29/2012. The corrective action will be completed and implemented by 3/6/2012.	03/06/2012

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F 323	Continued From page 15 The registered nurse (RN)-D, interviewed on 1/26/12 at approximately 11:10 a.m. stated she completed the incident report when R36 fell from the standing lift. RN-D stated she did not interview the staff present with R36 to determine if the lift had been utilized correctly or if the lift, sling or straps had failed. RN-D stated she talked with LPN-A on 1/4/12 when she filled out the incident report. Interview with nurse manager (NM-A) on 1/26/12 at approximately 10:45 a.m. indicated that the two staff present at the time of R36's fall from the standing lift should have been interviewed as part of the investigation.	F 323		
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.	F 356	F356 Failure to ensure the nursing staff posting contained the required information and was accessible to residents To ensure all residents in the facility have access to the staff posting the DON educated nursing staff on 2/02/2012 about the requirements for the staff posting form.	

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F 356	Continued From page 16 The facility must, upon oral or written request, make nurse staffing data available to the public 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 did not ensure the nursing staff posting contained the required information and was accessible to residents. This had the potential to affect all 42 residents in the facility. Findings include: The nurse staff posting was observed on a bulletin board approximately five feet from the floor, not accessible to residents at wheelchair height, on 1/23/12 through 1/26/12. The posting did not include the resident census or the total number of actual hours worked by registered nurses (RN), licensed practical nurse (LPN) and nursing assistants (NA). On 1/26/12 at 1:19 p.m. on 1/26/12, the director of nursing (DON) verified the nurse staff posting did not include the appropriate information and was not posted where it was accessible to all residents.	F 356	To ensure that this deficient practice does not reoccur, a policy will be developed and implemented regarding the requirements for the staff posting form and its accessibility to residents. A sample form and instructions will be provided to nursing staff to ensure all requirements are fulfilled. To ensure the corrective action is sustainable, the DON or her delegate will audit the staff posting form 5 days per week for 1 month. The above deficiency will be reviewed at the next Quality Assurance Meeting, which is tentatively scheduled for 3/20/2012. During the review, the corrective actions put into place along with any audits and their results will also be discussed among the attendees. The corrective action will be completed on or by 2/17/2012.	02/17/2012
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428	F428 The pharmacy consultant failed to identify low blood pressure.	

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F 428	Continued From page 17 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consultant pharmacist failed to identify low blood pressures for 1 of 10 residents (R47) in the sample reviewed for unnecessary medication use. Findings include: R47 had low blood pressures, received a blood pressure medication to control blood pressure, and her blood pressures were not monitored by the pharmacist. R47's diagnosis included essential hypertension (high blood pressure). R47 received the medication hydrochlorothiazide (a medication used to treat high blood pressure and fluid retention) 50 milligrams (mg) every day. A review of R47's blood pressures indicated the following low blood pressures: On 5/18/12, R47's blood pressure was 106/46 (a normal blood pressure is 120/80). On 8/31/12, R47's blood pressure was 120/40.	F 428	The pharmacy consultant completed a drug regimen review of resident R47 on 2/13/2012. The pharmacy consultant made a recommendation and the physician addressed on 2/22/2012. To ensure that other residents are not affected by this deficient practice, a blood pressure check and review policy will be developed and implemented on 3/5/2012. To ensure that this deficient practice will not reoccur, the licensed staff will review and enter the vital signs in to the computer. All blood pressures will be recorded in the vital sign section of the medical record for each resident. The DON or her delegate will perform 3 random audits weekly for twelve weeks to evaluate resident blood pressures and if necessary follow-up was completed for symptomatic blood pressures. The above deficiency will be reviewed at the next Quality Assurance Meeting, which is tentatively scheduled for 3/20/2012. During the review, the corrective actions put into place along with any audits and their results will also be discussed among the attendees. The licensed nursing staff will be educated on the blood pressure check and review policy at a nurse meeting tentatively scheduled on 2/29/2012.	

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F 428	Continued From page 18 On 11/23/11, R47's blood pressure was 110/20. The consultant pharmacist's drug regime was reviewed, and lacked review of the low blood pressures. The consultant pharmacist, interviewed by phone on 1/31/12 at 9:20 am, verified the lack of follow-up related to R47's low blood pressures.	F 428	The corrective action will be completed by 3/5/2012.	03/05/2012
F 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility did not ensure the call system was functional at all times for 2 of 40 residents (R23, R40) in the facility. In addition, call lights in occupied rooms 201, 203, 206, 209, 211, and 212 did not appear on the marquee (lighted sign that scrolled call light information) at the end of the hall. Findings include: On 1/23/12, at 4:33 p.m. on 1/23/12, R23's nurse call light was not functioning. R23's diagnosis included osteoarthritis, aphasia due to cerebrovascular disease and dementia. The care plan dated 1/13/12, indicated R23 had a cognitive decline, and required staff assist with dressing, grooming, bathing, mobility and toileting.	F 463	F463- Failure to ensure the call system was functional at all times throughout the facility and displayed on the marquee at the end of the hallway. The maintenance staff ordered the part to repair the South Wing marquee that was not displaying resident calls on 1/24/2012. The maintenance staff received and installed the part on 1/26/2012. The part failed and needed to be reordered. The part was reordered on 1/27/2012. The part was received on 2/20/2012 and installed the same day but failed to function properly. A new part was ordered on 2/20/2012. To ensure that other residents are not affected by this deficiency, the nursing staff checked all call lights for functional status on 1/23/2012.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING _____ B. WING _____	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(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 463	Continued From page 19 Nursing assistant (NA)-B, interviewed on 1/23/12 at 4:33 p.m., verified R23's call light did not show up on the hallway marquee and did not show up on his pager. NA-B stated R23 is able to use the call light. At 5:23 p.m. on 1/23/12, registered nurse A (RN-A) replaced R23's call light, and verified it worked on the staff pager systems and on the hallway marquee. On 1/26/12 at 10:57 a.m., the director of nursing (DON-B) reviewed the computerized call light response time logs and verified R23's call light was not working from 9:10 a.m. to 5:19 p.m. on 1/23/12. On 1/23/12, at 6:00 p.m., R40's nurse call light did not ring to the pagers or appear on the marquee at the end of the hall. R40 was not interviewable; however, the nurse call light was observed to be within reach on 1/23/12, at 6:00 pm. The mobility care plan dated as reviewed 11/24/11, directed "Encourage use of the call light to summon staff help." RN-A, interviewed on 1/23/12 at 6:00 p.m., verified R40's nurse call light was not working and did not appear on the marquee or on staff pagers. The call system in resident rooms did not display on the marquee of the South unit on 1/23/12. On 1/23/12 at 4:50 p.m., the nurse call light for room 209 was displayed on a monitor at the nursing desk; however, there was no audible alarm and no signal on the marquee at the end of the hall. There were no staff at the nursing desk. Activation of the call lights in the occupied resident rooms 201, 203, 206, 211, and 212 revealed that resident room and bathroom call	F 463	To ensure that this deficiency does not reoccur the facility replaced plastic call cord jacks with metal jacks to prevent internal wire damage which had been the cause of past call light failures. This corrective action was completed on 2/14/12. In addition, all of the resident room call cords were inspected for damages and replaced as needed on 2/14/12. Spare call cords will be made available for staff to have access to after environmental services exit each day. see addendum page 23. RCH 3/2/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING _____ B. WING _____	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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F 463	Continued From page 20 lights did not display on the marquee for the south unit. On 1/23/12, at 5:10 p.m., RN-A stated she had not heard about any "call light problems" and did not know the south hall marquee was not functioning. RN-A stated she would check to ensure the marquee was plugged in "for starters." At 5:27 p.m. on 1/23/12, RN-A stated the marque on the South unit had been unplugged. On 1/24/12 at 3:40 p.m., an audible alarm was heard on the west unit and the marquee was observed to be flashing. At 3:48 p.m. the director of nurses (DON) confirmed the marquee on the west unit was alarming and flashing, but the call system for the west unit was not functional. The DON stated the maintenance staff had been paged. The DON stated the facility did not have a policy for what to do if the marquee was not working. The DON stated, "I believe the rooms still alert on the pagers." The DON confirmed the marquee was the only external means to notify non-nursing staff of a call light, other than the computer and stated only nursing staff and the social worker were expected to answer call lights.	F 463	To ensure call lights remain functional, environmental service staff will perform daily call light checks for one month starting on 2/20/2012. During routine housekeeping tasks in each room, housekeeping staff will check call lights to ensure they are in functional order. The above deficiency will be reviewed at the next Quality Assurance Meeting, which is tentatively scheduled for 3/20/2012. During the review, the corrective actions put into place along with any audits and their results will also be discussed among the attendees. The corrective action will completed by 3/8/2012.	03/08/2012
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility	F 492	F492 Failure to ensure demand bill documentation was complete.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING _____ B. WING _____	01/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 492	Continued From page 21 did not submit a demand bill for 1 of 1 residents (R62) in the sample who requested a demand bill. Findings included: R62 did not have a demand bill submitted after it was requested on 12/8/11. Review of R62's "Continued Stay Denial Letters" form indicated R62 would no longer qualify as covered under Medicare beginning 12/13/11. The box "I do want my bill for services I continue to receive to be submitted to the intermediary for Medicare decision." was checked, the form was signed by R62's representative and dated 12/8/11. On 1/26/12 at 11:23 a.m., the business office manager and accounts receivable staff both confirmed that the demand will was not submitted as requested by R62's representative. Both staff confirmed a demand bill should have been submitted for R62.	F 492	Assessment of denial letter was completed on 2/7/2012. Business Manager clarified that forms need to be filled out to include that family/resident was given the option to request demand bill. The process of the tracking of the demand bill was reviewed. This information was given and reviewed with the Case Managers, DON and biller on 2/7/2012. On a weekly basis, at the Medicare meeting where the Case Managers and biller are present, they will perform an audit once a week for twelve weeks to review all denial letters to make sure that family/residents are given the option to request a demand bill and review the status of all demand bills in process. The above deficiency will be reviewed at the next Quality Assurance Meeting, which is tentatively scheduled for 3/20/2012. During the review, the corrective actions put into place along with any audits and their results will also be discussed among the attendees. The corrective action will be completed on and put into place on 2/7/2012.	02/07/2012

Galeon
growing stronger

March 1, 2012

Pat Halverson, Unit Supervisor
MN Dept. of Health
Government Services Center
320 W 2nd Street, #703
Duluth, MN 55802

Dear Pat:

Regarding the two questions you had about the Plan of Correction we (Community Memorial Home) submitted to you on 2-24-12, please consider my responses that follow:

F312-In addressing how the plan of correction is sustainable, upon any changes in the resident's plan of care, the Kardex will be removed from the resident's room and replaced with the updated version by the nurse making the change.

F463-After several failed attempts to repair the south wing display marquee with new parts, a technician from RFT (the company supplying the nurse call system) has been scheduled to repair the display marquee onsite at Community Memorial on Thursday, March 01, 2012. The marquee will be repaired or replaced by the completion date, March 8, 2012.

Thank you for your consideration of my responses. Please call me at 320-859-2142 or email me at dcarlson@galeonmn.com If you have additional questions about our plan of corrections.

Sincerely:

Dave Carlson

Dave Carlson, Administrator
Galeon

DC:ms

page 33

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Friday, March 23, 2012 9:34 AM
To: 'rochi_lsc@cms.hhs.gov'
Cc: Anderson, James A (DPS); 'Dave Carlson'; 'Colleen Leach'; 'Jim Loveland'; Leppke, Susan (MDH); 'Mark Meath'; 'Mary Henderson'; 'Shellae Dietrich'; Steege, Nicole (MDH); Whitney, Marian (DPS)
Subject: Community Memorial Home (245465) K67 Annual Waiver Request

This is to inform you that Community Memorial Home is requesting an annual waiver for K67, corridors as a plenum. The exit date was 1-26-12.

I am recommending that CMS approve this waiver request.

Patrick Sheehan, Fire Safety Supervisor
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division, Est. 1905
Office: 651-201-7205, Cell: 651-470-4416
FAX: 651-215-0525
Web: fire.state.mn.us

Name of Facility
COMMUNITY MEMORIAL HOME AT OSAKIS, MN INC.

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067 The building Heating, Ventilation & Air Conditioning Equipment(HVAC) does not comply with LSC(00) Section 9.2 and NFPA 90A, 199 Edition, because the corridors are used as a plenum.	An annual continuing wavier is being requested for K067 for the following reasons: A. Compliance with this provision will cause an unreasonable hardship on Community Memorial Home because: 1. Cost estimates obtained on 3-16-2012 (attached) indicate that compliance with NFPA 90A would cost between $420,000 and $537,000. 2. Community Memorial Home's electrical system would need to be modified at a cost ranging from $35,000 to $40,000 to support the new ducted system. 3. Installation of a ducted system would require asbestos abatement procedures costing between $55,000 and $75,000. 4. LSC(00), 9.2.1 allows non-complying systems to continue in use. B. There will be no adverse effects on the building's occupants's safety. if approved, because: 1. Our building is of Type II construction 2. The walls, floors, ceiling, and vertical openings resist the passage of smoke. 3. The building is protected throughout by completely supervised sprinkler system installed in accordance with NFPA 13, 1999 Edition. 4.The existing HVAC systems's ventilation fans automatically shut down activation of the fire alarm system or upon the detection of smoke. 5. Resident sleeping rooms are equipped with battery operated single station smoke detectors. 6. The facility is smoke-free and tobacco, and signs to that effect are posted. 7. The corridors are equipped with a UL listed smoke detection system that is in compliance. 8. The Fire Department is located less than 3/4 mile away and can respond to an alarm in under 15 minutes. 9. Community Memorial Home is in compliance with all other fire safety requirements and has a compliant fire safety plan. 10. An annual continuing wavier has been approved in the past for Community Memorial Home. Requested By: David E. Carlson, Admin. David E. Carlson, Administrator, 3-19-2012

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title **Fire Safety Supervisor**	Office **State Fire Marshal**	Date 3-23-12

Design Tree
ENGINEERING AND LAND SURVEYING

Alexandria Office
120 17th Avenue W.
Alexandria, MN 56308
(320) 762-1290

St. Cloud Office
3339 West St. Germain, Suite 250
St. Cloud, MN 56301
(320) 217-5557

March 16th, 2012

Dave Carlson
Galeon Community Memorial Home
410 W Main Street
Osakis, MN 56360

RE: **Site Evaluation and Construction Cost Estimate**

Dear Mr. Carlson,

Design Tree Engineering has evaluated the existing site conditions in regards to the Heating, Ventilation, and Air Conditioning (HVAC) systems. Below is a summary of our findings; and attached is a spreadsheet put together with the cost estimates to upgrade the HVAC system to directly supply air to the resident rooms.

The HVAC system to distribute the ventilation air to the residence rooms utilizes the hallway spaces as a supply duct plenum. In order to reconfigure the duct system, the entire hallway area would need to be remodeled to provide access to the ceiling space. New ductwork can then be installed, and routed directly into each resident room.

The current electrical lighting and other conduits, wiring, and low voltage would need to be relocated and or replaced to accommodate construction.

Some of the existing piping and ductwork has asbestos insulation on it. This would need to be removed in order to access the ducts and piping required.

During the construction process, several penetrations would need to be made in load bearing walls to allow ductwork into the resident rooms. These penetrations are small in size and do should not have a major impact on the structural integrity of the building. Exact structural scope would need to be verified during construction design.

The hallway ceiling space was evaluated to see if new ductwork could fit above current ceiling height. The East, West, and North corridors have 56 inches of space from the roof deck to the suspended ceiling. The South hall has more electrical and other items located in it. After evaluation, new ductwork will fit above the ceiling space in the corridors. Some modifications and relocations of items in ceiling space will be necessary. Exact scope would need to be verified during construction design.

Please feel free to contact us to discuss in further detail the findings of this report and the attached estimates.

Sincerely,

DESIGN TREE ENGINEERING INCORPORATED

Chris Schaefer

morton
CONSTRUCTION MANAGERS
"right from the start"
3315 Roosevelt Road, Ste. 100
St. Cloud MN 56301
Bus. (320) 251-0262 Fax: (320) 251-5749

PRELIMINARY MASTER BUDGET
Galeon - Community Memorial Home
PREPARED: 3/16/2012

	Low Range 24,000 S.F. DOLLARS		High Range 24,000 S.F. DOLLARS	
I. LAND				
SUBTOTAL LAND	$ -		$ -	
II. CONSTRUCTION COSTS				
GENERAL CONDITIONS	$ 25,000	$ 1.04	$ 30,000	$ 1.25
INTERIOR FINISHES / DEMO	$ 18,000	$ 0.75	$ 27,000	$ 1.13
MECHANICAL	$ 192,000	$ 8.00	$ 240,000	$ 10.00
FIRE SPRINKLER	$ 5,000	$ 0.21	$ 10,000	$ 0.42
ELECTRICAL	$ 35,000	$ 1.46	$ 40,000	$ 1.67
CONTINGENCY	$ 30,000	$ 1.25	$ 38,000	$ 1.58
SUBTOTAL CONSTRUCTION COSTS	$ 305,000	$ 12.71	$ 385,000	$ 16.04
III. SOFT COSTS				
FEES / PERMITS / PRINTING	$ 60,000	$ 2.50	$ 77,000	$ 3.21
OTHER	$ -	$ -	$ -	$ -
SUBTOTAL SOFT COSTS	$ 60,000	$ 2.50	$ 77,000	$ 3.21
IV. OWNER ITEMS				
FURNITURE/FIXTURES/EQUIPMENT	$ -		$ -	
Asbestos Abatement	$ 55,000		$ 75,000	
SUBTOTAL OWNER ITEMS COSTS	$ 55,000		$ 75,000	
V. TOTAL PROJECT COST	$ 420,000	$ 17.50	$ 537,000	$ 22.38

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(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	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. At the time of this survey, the 1963 and 1977 sections of Community Memorial Home were found to be 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: MR. PATRICK SHEEHAN, SUPERVISOR HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 Pat.Sheehan@state.mn.us ST. PAUL, MN 55101-5145	K 000	POC ok w/HW for K67 3-23-12 PS RECEIVED FEB 2 7 2012 MN DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 01.26.2012 DC: 3.07.2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David E. Carlson — TITLE: Administrator — (X6) DATE: 2-23-12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

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K 000	Continued From page 1 *****DO NOT FAX***** 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 facility was surveyed as two separate buildings. Community Memorial Home is a 2 story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1963, is one story and was determined to be of Type II(000) construction. In 1977, a one story, Type II(000), expansion to the dining room was added. Because the original 1963 building and the 1977 addition meet the construction type allowed for existing buildings, these buildings were surveyed as one existing building. The 2 story 2008 Wellness Center addition was surveyed as new construction. The building is fully fire sprinklered throughout. The facility has a fire alarm system that includes smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 43 at the time of the survey.	K 000		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	AW	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observations and an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include: During the facility tour between 10:30 AM and 12:30 PM on 01/30/12, an interview with the Facility Administrator (DC), a review of documentation and observations revealed that the HVAC systems for all wings of the 1963 and 1977 additions have ducted air supply to the corridors and no return or exhaust from the corridors. There is no supply or return in the	K 067	K067- A wavier continuation for K 067 is being requested for which justification dated ~~2/22/2012~~ on form CMS 2786R is attached.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 067	Continued From page 3 resident rooms, which all have bathroom exhaust fans that are constantly exhausting to the outside. This situation is using the corridors as a supply plenum. This was confirmed by the Facility Administrator (DC) An annual waiver has been previously granted.	K 067		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based upon observation and interview, the facility failed to provide a remote audible alarm panel, at a work site readily observable by personnel, in accordance with NFPA 110 (1999 edition) Chapter 3, Section 3-5.6.1. This deficient practice could adversely affect 43 of 43 residents, staff and visitors. FINDINGS INCLUDE: During the facility tour between 10:30 AM and 12:30 PM on 01/30/12, it was observed that the facility failed to provide the required with a remote, common audible alarm panel for the emergency generator at a constantly attended	K 144	K144 By 03/12/2012, the Director of Environmental Services or his designee will install a readily observable and common audible alarm remote annunciator panel at the constantly attended nurse's station that will show functions of the emergency generator as required by NFPA 110 (1999 Edition) Chapter 3, Section 3-5.6.1. Following installation, the Director or his designee will monitor and document its performance on a monthly basis. Completion Date: 03/12/2012	03/12/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 144	Continued From page 4 location. After an interview with the Facility Administrator (DC), it was also found that the facility was not equipped with a remote, common audible alarm panel for the emergency generator. This was confirmed by the Facility Administrator (DC)	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING 02 - 2 BLDG PT/OT WELLNES B. WING _____	01/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOME	410 WEST MAIN STREET OSAKIS, MN 56360

(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	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. At the time of this survey, the 2008 Wellness Center Addition of Community Memorial Home was found not to be 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 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: MR. PATRICK SHEEHAN, SUPERVISOR HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145	K 000	POC ok PS 3-23-12	

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

Edward E Carlson | Administrator | 2-23-12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING 02 - 2 BLDG PT/OT WELLNES B. WING _____	01/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 Pat.Sheehan@state.mn.us ST. PAUL, MN 55101-5145 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. Community Memorial Home was surveyed as two separate buildings. The 2008 Wellness Center addition is a 2-story building with no basement, and was determined to be of Type II (111) construction. The building is fully fire sprinklered throughout and has a fire alarm system that includes smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	K144 By 03/12/2012, the Director of Environmental Services or his designee will install a readily observable and common audible	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245465	A. BUILDING 02 - 2 BLDG PT/OT WELLNES B. WING	01/30/2012

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K 144	Continued From page 2 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based upon observation and interview, the facility failed to provide a remote audible alarm panel, at a work site readily observable by personnel, in accordance with NFPA 110 (1999 edition) Chapter 3, Section 3-5.6.1. This deficient practice could adversely affect 43 of 43 residents, staff and visitors. FINDINGS INCLUDE: During the facility tour between 10:30 AM and 12:30 PM on 01/30/12, it was observed that the facility failed to provide the required with a remote, common audible alarm panel for the emergency generator at a constantly attended location. After an interview with the Facility Administrator (DC), it was also found that the facility was not equipped with a remote, common audible alarm panel for the emergency generator. This was confirmed by the Facility Administrator (DC)	K 144	alarm remote annunciator panel at the constantly attended nurse's station that will show functions of the emergency generator as required by NFPA 110 (1999 Edition) Chapter 3, Section 3-5.6.1. Following installation, the Director or his designee will monitor and document its performance on a monthly basis. Completion Date: 03/12/2012	03/12/2012