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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 0UY0

Facility ID: 00542

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245594**

2. STATE VENDOR OR MEDICAID NO. (L2) **220043100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GIL-MOR MANOR**
(L4) **96 THIRD STREET EAST**
(L5) **MORGAN, MN** (L6) **56266**

4. TYPE OF ACTION: 2 (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **11/19/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

11. .LTC PERIOD OF CERTIFICATION

From (a) :

To (b) :

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (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)
___ 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*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS

1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :

Jodi Johnson, HFE NE II 12/17/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:

Kamala Fiske-Downing, Enforcement Specialist 12/30/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY

_____ 1. Facility is Eligible to Participate

_____ 2. Facility is not Eligible

(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **11/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS

A. Suspension of Admissions: (L44)

B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**

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

INVOLUNTARY

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

OTHER

07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Submitted
December 2, 2015

Ms. Terrie Frank, Administrator
Gil-Mor Manor
96 Third Street East
Morgan, MN 56266

RE: Project Number S5594026

Dear Ms. Frank:

On November 19, 2015, a standard survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

> **Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;**
>
> **No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);**
>
> **Appeal Rights - the facility rights to appeal imposed remedies;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 6 months after the survey date; and

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on November 19, 2015, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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:

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective December 6, 2015. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty of for the deficiency cited at F371, (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, 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 (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
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.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the 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 ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 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 latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by February 19, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 19, 2016 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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:

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING ______ B. WING ______	11/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	**96 THIRD STREET EAST** **MORGAN, MN 56266**

(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 Minnesota Department of Health conducted a standard survey on November 17, 18 and 19, 2015. The survey resulted in an Immediate Jeopardy (IJ) at F371 related to the facility's failed response to prepare unpasteurized eggs in a safe manner which resulted in the high potential for harm or death. The IJ began on November 19, 2015, at 10:26 a.m. when the administrator was notified. The IJ was removed on November 19, 2015, at 1:28 p.m. after it could be verified the facility had implemented a removal plan. However, non-compliance remained at the lower scope and severity level of a D, isolated, with no actual harm with a potential for no more than minimal harm. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 371 SS=J	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		11/19/15

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

Electronically Signed — 12/02/2015

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 371	Continued From page 1 under sanitary conditions	F 371		
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to prepare food in a safe manner related to the use of non-pasteurized eggs in the dietary department. This deficient practice resulted in an immediate jeopardy for 2 of 34 residents (R9, R21) for whom undercooked unpasteurized eggs were observed to have been prepared. The preparation of these undercooked eggs placed 2 residents (R9, R21) at risk for the development of the food borne illness, Salmonella Enteritis. This practice had the potential to affect all 34 residents in the facility. The immediate jeopardy (IJ) began on 11/19/15, due to the systemic failure of the facility to appropriately prepare unpasteurized eggs during observation of the breakfast meal, when yellow, runny egg yolks were served to R9 and R21. The practice of serving the undercooked eggs had the potential to cause Salmonella Enteritis. The administrator was notified of the IJ on 11/19/15, at 10:26 a.m. The IJ was removed on 11/19/15, at 1:28 p.m., however, noncompliance remained at the lower scope and severity level of D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: During the initial kitchen tour on 11/17/15, at		When deficient practice was identified and brought to the Administrators attention, she immediately met with the Dietary Manager to discuss and educate her regarding facility policy and procedures regarding the use of unpasteurized and pasteurized eggs. Dietary Manager was instructed to call area grocery providers to check on the availability of pasteurized eggs and purchase them for immediately use. Moving forward, Gil-Mor Manor will only purchase pasteurized eggs for all food preparation. The facility Food Preparation Policy and Procedures have been updated to state, “3) Purchase and use only pasteurized eggs in all food preparation”. The Administrator will monitor and review food orders weekly to ensure that the facility is only using pasteurized eggs in facilities food preparation. In addition, our Registered Dietician will audit during her consultation visits to ensure that the facility is only using pasteurized eggs in facilities food preparation and will include documentation of this in her monthly report to the Administrator. Corrective action completion date	

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F 371	Continued From page 2	F 371		

10:55 a.m. a large box was observed located on the bottom left side of the refrigerator which contained unpasteurized shell eggs. The dietary manager (DM) stated all shell eggs utilized by the facility were unpasteurized due to the egg shortage and difficulty obtaining pasteurized eggs. The DM stated that prior to the egg shortage, only pasteurized eggs had been used for resident consumption.

November 19, 2015.

When the facility weekly menus dated August 2015 thru November 2015 were reviewed, it was noted that "eggs of choice" was listed as an option for breakfast. Review of the facility's Ala Cart Dining menu included, "Eggs made to order including Fried, Scrambled, Poached, and Hard Boiled."

When interviewed on 11/18/15, at approximately 5:05 p.m. dietary aide (DA)-A confirmed residents could order eggs to their specifications, including fried eggs with a soft yolk and poached eggs.

During observation of the breakfast meal on 11/19/15, at approximately 7:15 a.m. R21 was observed to order a fried egg. At 7:25 a.m. dietary staff delivered 1 fried egg to the table where R21 was seated. It was observed when R21 cut into the fried egg, the egg yolk appeared yellow/runny and the yolk spilled out onto the plate. R21 was interviewed at that time and confirmed he preferred his eggs cooked as served (soft yolk).

When interviewed on 11/19/15, at 7:28 a.m. the dietary manager (DM) confirmed unpasteurized shell eggs were utilized in the dietary department as well as pasteurized liquid eggs. The DM confirmed R21 preferred his eggs cooked with a

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F 371	Continued From page 3 soft yolk and therefore staff honored this choice. After the surveyor prompted, the DM requested dietary staff to retrieve the runny egg served R21. DM confirmed she was aware that unpasteurized eggs should be properly cooked but stated there were two residents (R21, R5) who were adamant about wanting their eggs cooked soft/runny. The DM also acknowledged that unpasteurized eggs not cooked properly have a potential for food borne illness. However, DM further indicated she wanted to honor resident choice; and then added when it comes to choice vs. safety - safety should come first. At approximately 7:33 a.m., dietary staff returned after approaching R21 about the undercooked egg and stated R21 wouldn't agree to replace the soft, fried egg with another properly cooked egg. During further observation in the main dining room on 11/19/15, at approximately 7:45 a.m. R9 was observed seated at a table with a plate containing 2 poached eggs. It was observed that as R9 cut into one of the eggs, the yolk spilled out onto the plate with a watery type consistency. On 11/19/15, at 8:00 a.m. DM confirmed she had served R9 two (2) poached eggs per resident request after the surveyor had previously interviewed the DM related to (r/t) unpasteurized egg preparation and the potential for food borne illness. DM indicated she did not want to upset R9 if her request was denied; confirming that R9 always ordered soft poached eggs. DM confirmed she does not routinely check the temperature of eggs unless they are scrambled and further clarified it was not as much of an issue as pasteurized liquid egg products were utilized for scrambled eggs. When questioned further, the DM stated she was unsure of the date	F 371		

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F 371	Continued From page 4 the facility stopped ordering/receiving pasteurized eggs; indicating it was possibly this past spring (2015). She stated that at times the facility still received pasteurized eggs from their food source, US Foods, but when pasteurized eggs weren't available, unpasteurized eggs were ordered from the other supplier. The DM also confirmed she had received the memo dated 5/20/14, from CMS related to unpasteurized eggs and the potential for food borne illness. DM stated she had talked to a small group of residents, including R9 and R21 individually, about the potential risks of food borne illness when consuming soft cooked unpasteurized eggs. However, the DM confirmed such education had not been documented in the resident's records nor in staff meeting minutes. When interviewed on 11/19/15, at 8:14 a.m. R9 was asked whether staff had spoken with her related to the potential risk for food borne illness when ordering soft cooked eggs. R9 responded it didn't matter as the eggs used by dietary were pasteurized. When R9 was informed the eggs served were unpasteurized, R9 stated she was unaware of this and then responded it didn't matter because she was going to die of something and wanted her eggs cooked according to her choice. When interviewed on 11/19/15, at 8:15 a.m. R21 confirmed he always orders his eggs with a soft yolk and if unable to have them cooked per his preference, he probably wouldn't eat them. R21 stated staff may have discussed unpasteurized egg use but he still preferred them cooked to his specifications anyway. Review of the facility's food vendor invoices dated 10/15/15, 10/22/15, 10/29/15 and 11/5/15,	F 371		

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F 371	Continued From page 5	F 371		

indicated each shipment included 15 dozen shelled unpasteurized eggs. The invoices did not include any orders for shelled, pasteurized eggs.

Review of previous food vendor invoices dated 9/24/15, 10/1/15, 10/8/15, also did not include shelled, pasteurized eggs but only unpasteurized eggs.

Review of the food vendor invoice from the facility's other supplier, dated 9/30/15, 10/21/15, 11/4/15 and 11/11/15, also did not include any orders for shelled, pasteurized eggs.

A facility undated Food Preparation policy included:
3. Egg, Cheese, Dairy Cookery
a. Eggs
1) Use low to moderate heat.
2) Cook eggs until white and yolk are firm, not runny.
3) Recommend purchasing pasteurized or vendor guaranteed "salmonella free" eggs.
4) It is strongly recommended that soft cooked and poached eggs should not be offered to clients who may be susceptible to infections.
7) Poached (not recommended because of risk of salmonella infection)
·Water should be simmering, not boiling.
·Simmer 5 minutes to reach internal temperature of 145°F for 15 seconds. Cook until yolk and white are no longer liquid.
· Inform and document, re., the risk of salmonella infection with clients who request poached eggs.

The immediate jeopardy that began on 11/19/15, was removed on 11/19/15, when it was determined the administrator had provided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245594	A. BUILDING ______ B. WING ______	11/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	**96 THIRD STREET EAST MORGAN, MN 56266**

(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 371	Continued From page 6 education to the dietary manager regarding the use of unpasteurized eggs; had revised facility policies to reflect the facility will purchase and use only pasteurized eggs in all food preparation; had purchased pasteurized eggs for immediate use; had a plan in place for auditing food orders weekly to ensure the facility is only purchasing pasteurized eggs for food preparation; and had established monthly auditing by the registered dietician to ensure the facility is only using pasteurized eggs for facility's food preparation.	F 371		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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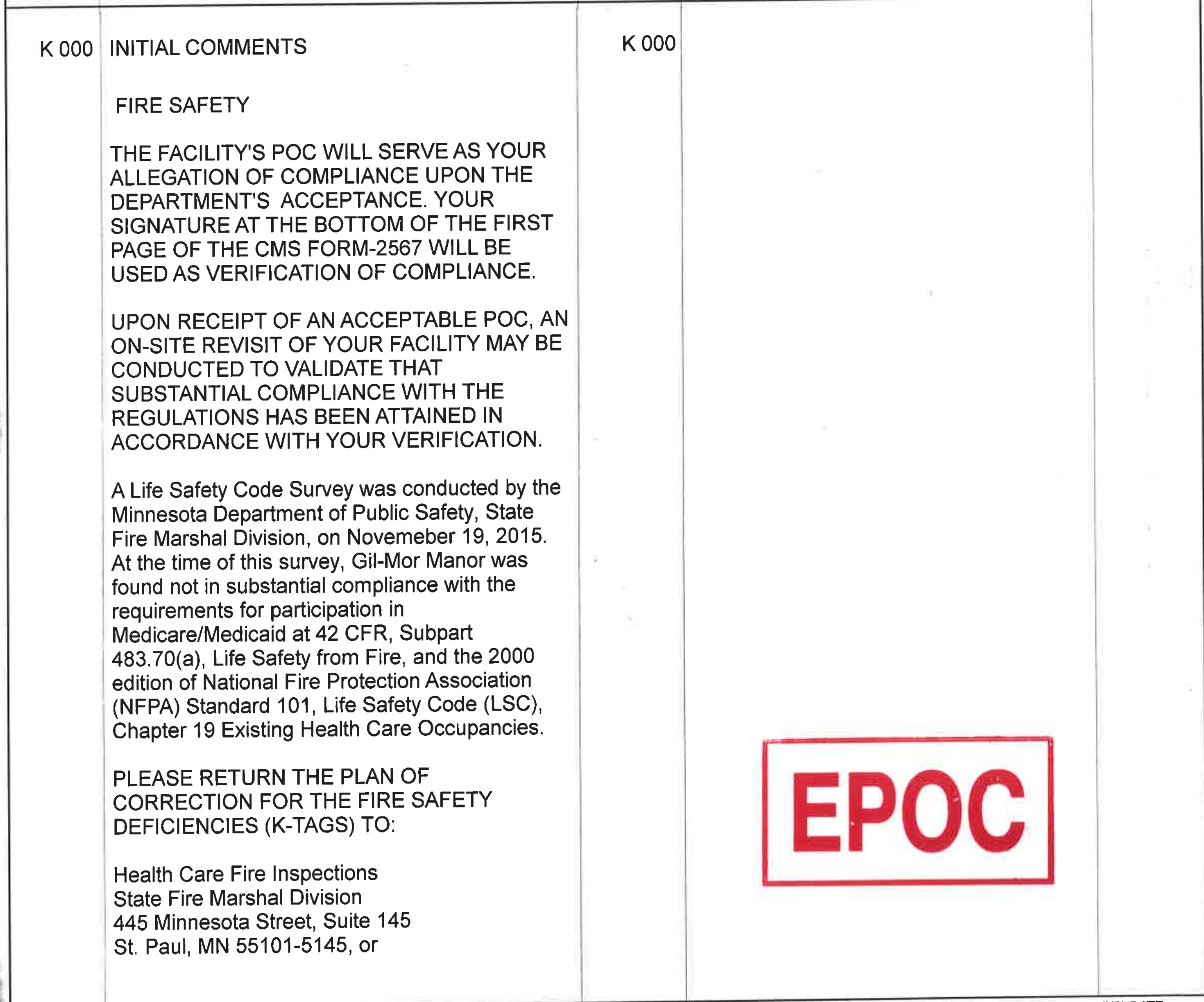
F5594025

PRINTED: 12/17/2015
FORM APPROVED
OMB NO. 0938-0391



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 000	INITIAL COMMENTS	K 000	EPOC	

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 FORM-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

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

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on Novemeber 19, 2015. At the time of this survey, Gil-Mor Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

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

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/10/2015

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	K 000		
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by:	K 050	On November 20, 2015, monthly fire drills were placed on a routine schedule and	11/20/15

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K 050	Continued From page 2 Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. Findings include: On facility tour between 08:30 AM and 10:30 AM on 11/19/2015, the review of the fire drill documentation for the past 12 months (October 2014 to October 2015) revealed the following: a. No fire drill documentation for the 1st, 2nd and 3rd shift during the 1st quarter (Jan-Mar) 2015 b. No fire drill documentation for the 2nd and 3rd shift during the 2nd quarter (Apr-Jun) 2015 This deficient practice was confirmed by the Administrator (TW) at the time of discovery.	K 050	the Maintenance staff will perform and document Gil-Mor Manor's quarterly fire drills on a rotating schedule to ensure that fire drills are performed for all three shifts during the quarter. Then on a quarterly basis at the QA&A meeting, the Maintenance staff will bring the Fire Drill Documentation book to be reviewed in order to ensure that fire drills were preformed and documented for all three shifts.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to properly maintain the fire sprinkler system in accordance with NFPA 101 Life Safety Code (2000 edition), Chapter 19, Section 19.7.6 and Chapter 4, Section 4.6.12 and NFPA 25 (1998 edition). In a fire emergency, this deficient	K 062	On November 20, 2015 a call was placed to Summit Fire Protection to setup quarterly fire sprinkler inspection as well as provide training to our two maintenance staff so that they can conduct these inspections moving	11/25/15

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K 062	Continued From page 3 practice could adversely affect 34 of 34 patients, staff and visitors. FINDINGS INCLUDE: On 11/19/2015 between 8:30 AM and 10:30 AM, during a review of available records, it was confirmed that required quarterly flow tests of the fire sprinkler system had not been conducted during the previous year. Quarterly flow tests are designed to test water flow alarm devices, pressure switches, water motor gongs and other required devices of a fire sprinkler system. This deficient practice was not in conformance with NFPA 25 (1998 edition) Chapter 2, Section 2-3 and Chapter 9, Section 9-2. This finding was confirmed with the Building Engineer (TW).	K 062	forward. Summit Fire Protection Systems conducted the quarterly fire sprinkler inspection on November 25, 2015 and provided training to our maintenance staff. Summit Fire Protection will follow-up in January 2016 again to get Gil-Mor Manor on track with their regularly scheduled quarterly inspections and provide additional training as necessary. Gil-Mor Manor's Quarterly Fire Sprinkler Inspection Schedule has been set as follows; January (quarterly) April (quarterly) July (annual/quarterly) October (quarterly) Maintenance will bring quarterly fire sprinkler inspection information to the quarterly QA&A meetings and will review with the Administrator and interdisciplinary team to ensure that Quarterly Fire Sprinklers Inspections have been completed timely. Completion date was November 25, 2015.	
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1	K 154		11/20/15

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K 154	Continued From page 4 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 08:30 AM and 10:30 AM on 11/19/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director (TW) at the time of discovery.	K 154	On November 20, 2015, Gil-Mor Manor developed and implemented a separate Fire Sprinkler System Out of Service policy utilizing the template available on the MN State Fire Marshal website and reads as follows; POLICY TITLE: FIRE SPRINKLER SYSTEM OUT OF SERVICE Page 1 of 3 APPROVED BY:____________ Effective Date: 11/20/2015 Revised Date: 11/20/2015 I. POLICY It is the policy of Gil-Mor to ensure that residents, staff and visitors are protected and that a safe environment is maintained during periods in which the building fire alarm system and/or fire sprinkler system is out of service. II. PURPOSE To outline interim fire/life safety measures that will be implemented during periods of time, preplanned or otherwise, in which the fire alarm system and/or fire sprinkler system at Gil-Mor is out of service. III. RESPONSIBILITY Responsibility for development and implementation of this policy rests with the facility safety officer.	

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K 154	Continued From page 5	K 154	IV. PROCEDURE A. Notifications 1. Upon finding that a required fire protection system is out of service: a. The following persons will be notified immediately: i. Facility Administrator Terrie Frank 507-828-5811 ii. Maintenance Contacts Tony Wildt 507-430-2364 or DeWayne Lyle 507-430-2858 iii. Local fire chief - Keith Hinrichs 507-828-1199 iv. The facility□s insurance carrier Guide One Insurance 515-267-5000 v. The facility□s monitoring company Protection Systems 320-252-2982 Account: B299090 Password: Herzo b. The facility operator will make an immediate announcement over the building PA system notifying staff of the nature and extent of the impairment and, in cases where the building□s fire alarm system is out of service, directing them to: i. Close all smoke and fire doors in the area(s) affected by the impairment; and ii. Unlock all locked exit doors in the area(s) affected by the impairment to allow for immediate egress in case of emergency. Residents who could pose a danger to themselves or others due to elopement must be closely monitored to ensure that they are accounted for at all times.	

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K 154	Continued From page 6	K 154		

2. If the building fire alarm and/or fire sprinkler system is out of service for more than 4 hours in a 24-hour period, Deputy State Fire Marshal Larry Gannon shall be notified by phone or e-mail at:
651-769-7779 or
larry.gannon@state.mn.us

POLICY TITLE: FIRE SPRINKLER SYSTEM OUT OF SERVICE
Page 2 of 3

APPROVED BY:______________________

Effective Date: 11/20/2015
Revised Date: 11/20/2015

B. Preplanned impairments
For preplanned impairments (e.g. scheduled work or testing), all the parties identified above will be notified, in advance, of the extent and expected duration of the impairment. In addition, the person performing the work will be expected to place tags (as appropriate) at each fire department connection, sprinkler system control valve, fire alarm control unit and/or fire alarm annunciator indicating that the system, or part thereof, has been removed from service.

C. Alternate fire alarm signal
Upon notification that the building fire alarm system is out of service, staff will immediately implement the following procedure, should a fire occur during the impairment:
a. The staff person discovering the fire

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K 154	Continued From page 7	K 154	must shout the code phrase RED LANTERN and go the aid of any person(s) in immediate danger. b. Personnel hearing the code phrase announced will immediately use the whistles provided at each nurse station to alert all other building occupants and then proceed to execute their duties as assigned in the fire safety plan. D. Fire watch At the direction of the fire chief, facility administrator or facility safety officer, a fire watch will be implemented. 1. Fire watch duties will be performed by facility maintenance staff who have been specially trained in identifying and controlling fire hazards, detecting early signs of unwanted fire, the use of portable fire extinguishers, and in occupant and fire department notification techniques. Evidence of such training will be maintained in each employee□s personnel file. 2. Fire watch personnel will: a. Have no other duties assigned to them while the affected fire protection system is out of service. b. Carry a cell phone with them to use for notification of the fire department. c. Perform continuous tours such that each portion of the building affected by the impairment is checked at not less than 30-minute intervals. In addition to watching for and promptly reporting any incidents of fire, visible smoke or strong smell of smoke or other unwanted odors, the fire watch will also ensure while on tour that:	

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K 154	Continued From page 8	K 154	"Portable fire extinguishers are in place, unobstructed and in proper operating condition; "Corridors and exits are free and clear of storage and all other obstructions; "Exit and stairwell doors are clear and fully operational; "EXIT signs are visible and properly illuminated; "Fire doors, smoke barrier doors and hazardous area doors are kept closed and latched (i.e. not tied, wedged or blocked open in any fashion); "Oxygen cylinders/containers not in use are properly stored; "Electrical hazards are promptly reported and remedied; POLICY TITLE: FIRE SPRINKLER SYSTEM OUT OF SERVICE Page 3 of 3 APPROVED BY:______ Effective Date: 11/20/2015 Revised Date: 11/20/2015 "No smoking or work involving cutting or welding or the use of flammable/combustible liquids is taking place (unless such work has been preauthorized and is taking place in an area that is properly fire separated from the remainder of the facility); and "Trash and other unnecessary accumulations of combustibles are promptly removed from the building. d. Document their tours in a log. Any	

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K 154	Continued From page 9	K 154	problems found during the fire watch will also be documented and reported to the head of maintenance for immediate correction. 3. The fire watch will remain in place until the impaired system has been restored to normal working order and fire watch personnel are relieved of their duties by the fire chief, facility administrator or facility safety officer. E. Evacuation The nature and extent of the impairment, coupled with other extenuating circumstances, may dictate that the building, or portions thereof, be completely evacuated. Such evacuations will be performed in accordance with the fire safety plan and take place only at the direction of the fire chief, facility administrator or facility safety officer. F. System(s) restored to service When the impaired system has been restored to normal working order: a. The following persons will be notified immediately: i. Facility Administrator Terrie Frank 507-828-5811 ii. Maintenance Contacts Tony Wildt 507-430-2364 or DeWayne Lyle 507-430-2858 iii. Local fire chief Keith Hinrichs 507-828-1199 iv. The facility□s insurance carrier Guide One Insurance 515-267-5000 v. The facility□s monitoring company □ Protection Systems 320-252-2982	

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K 154	Continued From page 10	K 154	Account: B299090 Password: Herzo b. The facility operator will make an announcement over the building PA system notifying staff that the system has been restored, smoke and fire doors can be reopened, exit door security restored and they can return to their regular routine. c. If notified that the building fire alarm and/or fire sprinkler system was out of service, Deputy State Fire Marshal Larry Gannon shall be informed that the impaired system has been restored to normal working order by calling: 651-769-7779 d. Any tags placed on fire department connections, fire sprinkler system control valves, fire alarm control units and/or fire alarm annunciator panels will be promptly removed. Completion date for this correction was 11/20/2015.	
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8	K 155		11/20/15

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K 155	Continued From page 11 This STANDARD is not met as evidenced by: Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 08:30 AM and 10:30 AM on 11/19/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director (TW) at the time of discovery.	K 155	On November 20, 2015, Gil-Mor Manor developed and implemented a separate Fire Alarm System Out of Service policy utilizing the template available on the MN State Fire Marshal website and reads as follows; POLICY TITLE: FIRE ALARM SYSTEM OUT OF SERVICE Page 1 of 3 APPROVED BY:________________________ Effective Date: 11/20/2015 Revised Date: 11/20/2015 I. POLICY It is the policy of Gil-Mor to ensure that residents, staff and visitors are protected and that a safe environment is maintained during periods in which the building fire alarm system and/or fire sprinkler system is out of service. II. PURPOSE To outline interim fire/life safety measures that will be implemented during periods of time, preplanned or otherwise, in which the fire alarm system and/or fire sprinkler system at Gil-Mor is out of service. III. RESPONSIBILITY Responsibility for development and implementation of this policy rests with the facility safety officer.	

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	245594	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**11/19/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GIL-MOR MANOR	**96 THIRD STREET EAST** **MORGAN, MN 56266**

(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 155	Continued From page 12	K 155	IV. PROCEDURE A. Notifications 1. Upon finding that a required fire protection system is out of service: a. The following persons will be notified immediately: i. Facility Administrator Terrie Frank 507-828-5811 ii. Maintenance Contacts Tony Wildt 507-430-2364 or DeWayne Lyle 507-430-2858 iii. Local fire chief - Keith Hinrichs 507-828-1199 iv. The facility□s insurance carrier Guide One Insurance 515-267-5000 v. The facility□s monitoring company Protection Systems 320-252-2982 Account: B299090 Password: Herzo b. The facility operator will make an immediate announcement over the building PA system notifying staff of the nature and extent of the impairment and, in cases where the building□s fire alarm system is out of service, directing them to: i. Close all smoke and fire doors in the area(s) affected by the impairment; and ii. Unlock all locked exit doors in the area(s) affected by the impairment to allow for immediate egress in case of emergency. Residents who could pose a danger to themselves or others due to elopement must be closely monitored to ensure that they are accounted for at all times. 2. If the building fire alarm and/or fire	

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K 155	Continued From page 13	K 155	sprinkler system is out of service for more than 4 hours in a 24-hour period, Deputy State Fire Marshal Larry Gannon shall be notified by phone or e-mail at: 651-769-7779 or larry.gannon@state.mn.us POLICY TITLE: FIRE ALARM SYSTEM OUT OF SERVICE Page 2 of 3 APPROVED BY:________ Effective Date: 11/20/2015 Revised Date: 11/20/2015 B. Preplanned impairments For preplanned impairments (e.g. scheduled work or testing), all the parties identified above will be notified, in advance, of the extent and expected duration of the impairment. In addition, the person performing the work will be expected to place tags (as appropriate) at each fire department connection, sprinkler system control valve, fire alarm control unit and/or fire alarm annunciator indicating that the system, or part thereof, has been removed from service. C. Alternate fire alarm signal Upon notification that the building fire alarm system is out of service, staff will immediately implement the following procedure, should a fire occur during the impairment: a. The staff person discovering the fire must shout the code phrase RED	

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K 155	Continued From page 14	K 155		

LANTERN and go the aid of any person(s) in immediate danger.
b. Personnel hearing the code phrase announced will immediately use the whistles provided at each nurse station to alert all other building occupants and then proceed to execute their duties as assigned in the fire safety plan.

D. Fire watch
At the direction of the fire chief, facility administrator or facility safety officer, a fire watch will be implemented.
1. Fire watch duties will be performed by facility maintenance staff who have been specially trained in identifying and controlling fire hazards, detecting early signs of unwanted fire, the use of portable fire extinguishers, and in occupant and fire department notification techniques. Evidence of such training will be maintained in each employee□s personnel file.
2. Fire watch personnel will:
a. Have no other duties assigned to them while the affected fire protection system is out of service.
b. Carry a cell phone with them to use for notification of the fire department.
c. Perform continuous tours such that each portion of the building affected by the impairment is checked at not less than 30-minute intervals. In addition to watching for and promptly reporting any incidents of fire, visible smoke or strong smell of smoke or other unwanted odors, the fire watch will also ensure while on tour that:
"Portable fire extinguishers are in place,

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K 155	Continued From page 15	K 155	unobstructed and in proper operating condition; "Corridors and exits are free and clear of storage and all other obstructions; "Exit and stairwell doors are clear and fully operational; "EXIT signs are visible and properly illuminated; "Fire doors, smoke barrier doors and hazardous area doors are kept closed and latched (i.e. not tied, wedged or blocked open in any fashion); "Oxygen cylinders/containers not in use are properly stored; "Electrical hazards are promptly reported and remedied; POLICY TITLE: FIRE ALARM SYSTEM OUT OF SERVICE Page 3 of 3 APPROVED BY:______________ Effective Date: 11/20/2015 Revised Date: 11/20/2015 "No smoking or work involving cutting or welding or the use of flammable/combustible liquids is taking place (unless such work has been preauthorized and is taking place in an area that is properly fire separated from the remainder of the facility); and "Trash and other unnecessary accumulations of combustibles are promptly removed from the building. d. Document their tours in a log. Any problems found during the fire watch will	

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K 155	Continued From page 16	K 155	also be documented and reported to the head of maintenance for immediate correction. 3. The fire watch will remain in place until the impaired system has been restored to normal working order and fire watch personnel are relieved of their duties by the fire chief, facility administrator or facility safety officer. E. Evacuation The nature and extent of the impairment, coupled with other extenuating circumstances, may dictate that the building, or portions thereof, be completely evacuated. Such evacuations will be performed in accordance with the fire safety plan and take place only at the direction of the fire chief, facility administrator or facility safety officer. F. System(s) restored to service When the impaired system has been restored to normal working order: a. The following persons will be notified immediately: i. Facility Administrator Terrie Frank 507-828-5811 ii. Maintenance Contacts Tony Wildt 507-430-2364 or DeWayne Lyle 507-430-2858 iii. Local fire chief Keith Hinrichs 507 -828-1199 iv. The facility□s insurance carrier Guide One Insurance 515-267-5000 v. The facility□s monitoring company □ Protection Systems 320-252-2982 Account: B299090 Password:	

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K 155	Continued From page 17	K 155	Herzo b. The facility operator will make an announcement over the building PA system notifying staff that the system has been restored, smoke and fire doors can be reopened, exit door security restored and they can return to their regular routine. c. If notified that the building fire alarm and/or fire sprinkler system was out of service, Deputy State Fire Marshal Larry Gannon shall be informed that the impaired system has been restored to normal working order by calling: 651-769-7779 d. Any tags placed on fire department connections, fire sprinkler system control valves, fire alarm control units and/or fire alarm annunciator panels will be promptly removed. Completion date for this correction was 11/20/2015.	