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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 1QLQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00110

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245510**

2.STATE VENDOR OR MEDICAID NO.
(L2) **414490000**

3. NAME AND ADDRESS OF FACILITY
(L3) **EVANSVILLE CARE CENTER 649**
(L4) **STATE STREET NORTHWEST**
(L5) **EVANSVILLE, MN** (L6) **56326**

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) **09/23/2009**

6. DATE OF SURVEY **2/3/2014** (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 **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(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 :
Tammy Williams, HFE NE II — 2/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 4/11/2014 (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
01/01/1988
(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
12/27/2013
(L33)

DETERMINATION APPROVAL

On November 14, 2013 a standard survey was completed at this facility. The most serious deficiency was cited at a S/S level of D.

On January 13, 2014, a PCR was completed for health and life safety code. Life Safety Code verified correction of all deficiencies. However health reissued two deficiencies F431 and F505 (both at a S/S level of D). As a result of this revisit, this Department imposed the Category 1 remedy of State monitoring, effective January 28, 2014. In addition we recommended the following remedy to the CMR RO for imposition:

-Mandatory Denial of Payment for new Medicare and Medicaid Payments, effective February 14, 2014

If DOPNA went into effect, the facility would have been subject to a loss of NATCEP for two years, beginning February 14, 2014.

On February 3, 2014, a PCR was completed by health and verified correction of the remaining deficiencies. As a result of this most recent PCR, the Category 1 remedy of State monitoring was discontinued, effective February 3, 2014. In addition, we are recommending the following to the CMS RO for imposition:

-Mandatory Denial of Payment for new Medicare and Medicaid Payments, effective February 14, 2014, be rescinded.

Since DOPNA never went into effect, the facility would not be subject to a two year loss of NATCEP. Please refer to CMS 2567.

Effective February 3, 2014, the above facility is certified for 40 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245510

April 7, 2014

Mr. Brandon Borgstrom, Administrator
Evansville Care Center
649 State Street Northwest
Evansville, MN 56326

Dear Mr. Borgstrom:

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 February 3, 2014, the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

February 17, 2014

Mr. Brandon Borgstrom, Administrator
Evansville Care Center
649 State Street Northwest
Evansville, Minnesota 56326

RE: Project Number S5510024

Dear Mr. Borgstrom:

On January 23, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective January 28, 2014. (42 CFR 488.422)

On January 23, 2014, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 14, 2014. (42 CFR 488.417 (b))

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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 14, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on November 14, 2013, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on January 13, 2014. The most serious deficiencies at the time of the revisit were found 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 February 3, 2014, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on January 13, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 18, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on January 13, 2014, as of February 3, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 3, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of January 23, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 14, 2014, 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 February 14, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective February 14, 2014, is to be rescinded.

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 February 14, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on February 3, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5510R2_14.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
245510	A. Building B. Wing	2/3/2014

Name of Facility	Street Address, City, State, Zip Code
EVANSVILLE CARE CENTER	649 STATE STREET NORTHWEST EVANSVILLE, MN 56326

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 F0431 Reg. # 483.60(b), (d), (e) LSC	02/03/2014	ID Prefix F0505 Reg. # 483.75(j)(2)(ii) LSC	02/03/2014	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 MM/GA	Date: 02/17/14	Signature of Surveyor: 32603	Date: 02/03/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 11/14/2013		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: 1QLQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00110

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245510**

2.STATE VENDOR OR MEDICAID NO.
(L2) **414490000**

3. NAME AND ADDRESS OF FACILITY
(L3) **EVANSVILLE CARE CENTER**
(L4) **649 STATE STREET NORTHWEST**
(L5) **EVANSVILLE, MN** (L6) **56326**

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) **09/23/2009**

6. DATE OF SURVEY **01/13/2014** (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 **40** (L18)

13.Total Certified Beds **40** (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
	40			
(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 :
Tammy Williams, HFE NEII — 01/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Program Specialist — 03/20/2014 (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
01/01/1988
(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 03/28/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/27/2013
(L33)

DETERMINATION APPROVAL

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

CCN=245510

On January 13, 2014 a Post Certification Revisit (PCR) was completed by health and life safety code to verify correction of deficiencies issued pursuant to the standard survey completed November 14, 2013. Health deficiencies were found not corrected , the most serious health deficiencies were reissued at a scope and severity Level of D, where corrections are required. Refer to the CMS 2567 (for health only), CMS 2567b (for both health and life safety code. PCR to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7968

January 23, 2014

Mr. Brandon Borgstrom, Administrator
Evansville Care Center
649 State Street Northwest
Evansville, Minnesota 56326

RE: Project Number S5510024

Dear Mr. Borgstrom:

On December 9, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 14, 2013. 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 13, 2014, the Minnesota Department of Health and on January 10, 2014, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 14, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 18, 2013. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on November 14, 2013. The deficiency(ies) not corrected is/are as follows:

- **F0431 -- S/S: D -- 483.60(b), (d), (e) -- Drug Records, Label/store Drugs & Biologicals**
- **F0505 -- S/S: D -- 483.75(j)(2)(ii) -- Promptly Notify Physician Of Lab Results**

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- **State Monitoring effective January 28, 2014. (42 CFR 488.422)**

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 February 14, 2014. (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 February 14, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 14, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

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: 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.

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:

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537-3858

Telephone: (218)332-5140
Fax: (218) 332-5196

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 May 14, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245510	A. Building B. Wing	1/13/2014

Name of Facility	Street Address, City, State, Zip Code
EVANSVILLE CARE CENTER	649 STATE STREET NORTHWEST EVANSVILLE, MN 56326

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 **F0241** Reg. # **483.15(a)** LSC	**12/18/2013**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	GA/AK	01/23/2014	32603	01/13/2014
Reviewed By CMS RO				

Followup to Survey Completed on: 11/14/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

AH Form Approved
1/22/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00110	A. Building B. Wing	1/13/2014

Name of Facility	Street Address, City, State, Zip Code
EVANSVILLE CARE CENTER	649 STATE STREET NORTHWEST EVANSVILLE, MN 56326

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 21805 Reg. # MN St. Statute 144.651 Sul LSC	Correction Completed 12/18/2013	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 GA/AK	Date: 01/23/2014	Signature of Surveyor: 32603	Date: 01/13/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 11/14/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245510	A. Building B. Wing **01 - MAIN BUILDING 01**	1/10/2014

Name of Facility	Street Address, City, State, Zip Code
EVANSVILLE CARE CENTER	649 STATE STREET NORTHWEST EVANSVILLE, MN 56326

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 K0025	**12/11/2013**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	01/23/2014	27200	01/10/2014
CMS RO				

Followup to Survey Completed on: 11/13/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7968

January 23, 2014

Mr. Brandon Borgstrom, Administrator
Evansville Care Center
649 State Street Northwest
Evansville, Minnesota 56326

Re: Enclosed Reinspection Results - Project Number S5510024

Dear Mr. Borgstrom:

On January 13, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 14, 2013, with orders received by you on December 10, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245510	A. BUILDING _____ B. WING _____	R 01/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE CARE CENTER	649 STATE STREET NORTHWEST EVANSVILLE, MN 56326

(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 An onsite revisit was conducted by the MDH on 1/13/14, and during this visit the following regulations were determined not to be corrected.	{F 000}		
{F 431} SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	{F 431}	All medication storage was audited. All have proper labeling and no out dated expiration dates. Medication stored in other storage areas, med carts and medication fridge, have been checked to ensure no outdated medications. Delegated nurse has been re-educated for completeness of documentation. All staff administering medications have been educated to check the expiration dates. Policy and procedure reviewed and revised as needed to reflect current practice. A weekly audit will be completed by the DON and brought to the QA meeting for ongoing compliance. Date of completion 1/15/14. OK 1/29/14 Vanlandeen	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 1-28-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245510	A. BUILDING _____ B. WING _____	R 01/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE CARE CENTER	649 STATE STREET NORTHWEST EVANSVILLE, MN 56326

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{F 431}	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to remove expired medications from stock supply available for use for residents in 1 of 1 stock medication cupboard in the facility. Findings include: During observation of medication storage on 1/13/14, at 11:50 a.m., four cartridges of expired omeprazole were noted stored in a stock medication cupboard, located in the facility's medication storage room. All four cartridges had expiration dates of 02/2013. Two of the cartridges were missing one tablet each, one cartridge was missing five tablets and one cartridge was missing three tablets. During interview on 1/13/14, at 12:04 p.m., registered nurse (RN)-A confirmed the above findings and confirmed the medications were available to be used for residents in the facility. RN-A reported she was unaware of the expired medications and stated the night shift nurse was supposed to be going through the cupboard to ensure there were no expired medications. During interview on 1/13/14, at 2:00 p.m., the director of nursing (DON) reported the night shift nurse had been completing audits to ensure there were no expired medications in the stock medication cupboard. The DON reviewed the last audit completed on 1/10/14, indicated that there were no expired medications found or	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245510	A. BUILDING _____ B. WING _____	R 01/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE CARE CENTER	649 STATE STREET NORTHWEST EVANSVILLE, MN 56326

(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 431}	Continued From page 2 removed from the cupboard. The DON stated it was an error made by the nurse herself, and would have to re-educate and audit the nurse. The DON confirmed that the expired medications were in a stock medication cupboard and could have been dispensed to any resident. The facility's undated policy titled ID1: Storage of Medications section M, indicated outdated medications were to be "immediately removed from stock", disposed of according to medication disposal procedures and reordered.	{F 431}		
{F 505} SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain physician acknowledgement and orders for laboratory results for 1 of 3 residents (R44) who received Coumadin (blood thinner). Findings include: Review of 44's medical record revealed 44 had diagnoses which included atrial fibrillation (irregular heartbeat). A physician order dated 11/27/13 directed: #1. Increase Coumadin to 1.25 mg by mouth on Monday, Wednesday, Friday and Saturday. #2. Increase Coumadin to 2.5 mg by mouth on Tuesday, Thursday and Sunday. #3. Recheck INR (international normalization	{F 505}		

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
	245510	A. BUILDING _____ B. WING _____	R 01/13/2014

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{F 505}	Continued From page 3 ratio-lab test to measure blood coagulation) in 1 month. The medical record included a INR laboratory result dated 12/26/13, however, there was no physician acknowledgement or further orders for the continued use of Coumadin regarding the results. During interview on 1/13/14 at 2:07 p.m., registered nurse (RN)-A confirmed the physician had not acknowledged the laboratory results dated 12/26/13, and also confirmed the facility had not received any further orders for the Coumadin. During interview on 1/13/14 at 1:55 p.m., the director of nursing (DON) confirmed the physician had not acknowledged the laboratory results dated 12/26/13, even though a nurse had documented that in fact the physician did acknowledge the results. The DON confirmed R44 had been receiving the dosage of Coumadin based on the 11/27/13 laboratory results. The DON indicated she would expect nursing staff to promptly notify the physician of laboratory results and receive further orders for the continued dose of Coumadin based on the laboratory results. The policy dated 3/2013, titled Lab Policy, identified laboratory tests were completed as soon as possible after receiving orders to ensure that medical interpretation and evaluation could be done within a reasonable length of time.	{F 505}	MD made aware of situation. Alexandria Protime clinic contacted. No changes in medications or treatments at this time. The lab log was modified. Policy and procedure regarding lab log was reviewed and revised as necessary. The Charge RN or designated licensed staff will review lab orders daily and verify that lab orders have been addressed by the MD and signed off. They will ensure this by observing a verified MD order, progress note ect. The DON will complete audits weekly and sign weekly to ensure that lab log is completed. Results of the audits will be reviewed at the QA meeting to ensure ongoing compliance. Date of completion 1/15/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245510	A. BUILDING _____ B. WING _____	R 01/13/2014

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

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	245510	A. BUILDING _____ B. WING _____	R 01/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245510	A. BUILDING _____ B. WING _____	R 01/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE CARE CENTER	**649 STATE STREET NORTHWEST EVANSVILLE, MN 56326**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245510	A. BUILDING _____ B. WING _____	R 01/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 1QLQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00110

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245510**

2.STATE VENDOR OR MEDICAID NO.
(L2) **414490000**

3. NAME AND ADDRESS OF FACILITY
(L3) **EVANSVILLE CARE CENTER**
(L4) **649 STATE STREET NORTHWEST**
(L5) **EVANSVILLE, MN** (L6) **56326**

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) **09/23/2009**

6. DATE OF SURVEY 11/14/2013 (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 **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 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

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
	40			
(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 :
Denise Erickson, HFE NE II 12/24/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 12/26/2013 (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
01/01/1988
(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

CCN=245510

At the time of the standard survey completed 11/14/2013 facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 6400

December 9, 2013

Mr. Brandon Borgstrom, Administrator
Evansville Care Center
649 State Street Northwest
Evansville, Minnesota 56326

RE: Project Number S5510024

Dear Mr. Borgstrom:

On 11/14/2013 a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

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

Telephone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 25, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 15, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may

still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 15, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245510	A. BUILDING _____ B. WING _____	11/14/13

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE CARE CENTER	649 STATE STREET NORTHWEST EVANSVILLE, MN 56326

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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.	F 000		
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 observation, interview and document review, the facility failed to provide care for 1 of 3 residents (R27) in the sample reviewed for assistance with activities of daily living, in a manner which enhanced the resident's dignity by ensuring the resident's personal body odor was minimized. Findings include: During observation on 11/12/13, at 4:21 p.m., R27 was observed to be fully dressed and seated on a folding chair in his room. The resident's bed was observed to be made, and a recliner with cloth upholstery was located next to the bed and	F 241	12/12/13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 12-12-13

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.

RECEIVED
DEC 17 2013
MN Dept of Health
Fergus Falls

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F 241	Continued From page 1 the seat was covered with a small patchwork quilt. There was a strong ammonia type odor noted in the room, with the odor being strongest near R27. During interview on 11/13/13, at 3:27 p.m., nursing assistant (NA)-A confirmed R27 did sometimes have a strong odor, and stated the odor was usually stronger in the afternoon and evening than in the morning. NA-A stated she felt there were various causes for R27's foul odor and indicated the reasons included urinary incontinence, frequent refusals to "get washed up" prior to going to bed, and because R27 often "eats sardines in his room." During an interview on 11/13/13, at 3:53 p.m., registered nurse (RN)-A confirmed R27's room had a foul odor and indicated she was unsure of the cause of the odor. R27 was observed to ambulate in the hallway past the front desk towards the main lobby on 11/14/13, at 7:14 a.m.. R27 ambulated very slowly and there was a strong ammonia type odor permeating from R27, which was perceptible from approximately six feet away. During an interview on 11/14/13, at 7:22 a.m. NA-B stated R27 had washed himself independently, including his bottom, with a soapy washcloth this morning prior to getting dressed in clean clothing. NA-B also stated R27 received 2 showers per week. During interview on 11/14/13, at 7:27 a.m. housekeeping (HC)-A, confirmed R27 routinely has a strong ammonia type odor. She further stated all resident rooms were cleaned daily and	F 241		

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F 241	Continued From page 2	F 241		

that bed linens were changed weekly and as needed. HC-A stated R27's sheets needed to be changed more often and also his bathroom needed to be cleaned some times up to 2 times a day. HC-A confirmed the extra care to R27's bathroom was to provide a fresh bathroom for the other resident who shared the space. HC-A also stated housekeeping followed these extra steps when cleaning R27's room: Clorox used to wash the floors, frequent removal of garbage because of wet incontinent products and empty sardine cans, deodorizer spray in the room, and opening the window to eliminate the foul odor.

At 9:03 a.m. on 11/14/13, R27 was again observed to ambulate slowly in the hall. The resident was observed to be assisted by NA-A to ambulate into the day room and to sit in a stationary chair near the front desk. The strong ammonia type odor was noted to continue to permeate from the resident.

During interview on 11/14/13, at 9:14 a.m. the director of nursing (DON) confirmed R27 had a strong body odor. The DON confirmed the plan of care which indicated R27 required assistance with bathing and grooming was current. The DON stated no new interventions had been attempted in the recent past to help with eliminating the resident's body odor.

During interview on 11/14/13, at 9:56 a.m. R27 indicated he had not been offered any more bathing or showering times and stated he would like more showers each week then he was presently receiving.

R27's record was reviewed. According to an annual Minimum Data Set (MDS) assessment

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F 241	Continued From page 3 dated 7/5/13, R27's diagnoses included: urinary incontinence, dementia, and Parkinson's disease. In addition, this MDS indicated R27 had intact cognition, required extensive assistance from staff with hygiene needs, required physical assistance with bathing, and was frequently incontinent of urine. The corresponding Care Area Assessment dated 7/19/13, indicated R27's cognitive status fluctuated, that R27 had experienced a decline in mood, had physical limitations, incontinence of urine, and required supervision and occasional assist from staff due to a shuffling gait related to his Parkinson's disease. R27's care plan, with a revision date of 7/23/13, revealed focus need areas of: "Dressing, Grooming, Bathing: Requires assist d/t [due to] weakness and, Toileting: Has incontinence of bladder and occasional bowel. Has urgency, dribbling of urine. Will request assist when needed." Care plan interventions included: "set up and assist as needed with partial bath, dressing and grooming upper/lower body AM [mornings], PM [evening] and when ever soiled, daily. Shower done weekly with assist from staff." In addition interventions included; Staff to offer/cue resident for toileting per plan and request to be woke one time during the night. Resident is able to toilet self or use a urinal. Will ask for assist as needed. Does have occasional incontinence of bladder, wears an incontinent pad and is assisted to adjust pads and clothing. Peri-cares are performed by staff after incontinent episode as he requests." The care plan also indicated R27 had difficulty with dropping and spilling things on the floor related to Parkinson's disease. The interventions indicated housekeeping should clean the	F 241	R27 has been reassessed for his personal care needs and interventions have been put in place to assure R27 is receiving the needed care to protect against odor and promote personal dignity. Interventions are in place for R27 to receive assistance with cares in AM, before meals, at HS, at least once during night shift and also as needed. R27 bath schedule will be 2x weekly. Resident is supplied with personal care products to aid in eliminating odors and enhance personal dignity. All residents will continue to be assessed for their personal care needs to assure all residents receive adequate and appropriate care to protect and promote personal dignity. Education will be provided to all nursing staff on 12/17/18. Audits will be completed by licensed nursing staff weekly x 2mths then monthly x 2 then quarterly with result reviewed by the DON. DON will submit a summary of the audits to the QA meeting for ongoing compliance. Time of completion 12/18/13.	

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F 241	Continued From page 4 resident's room daily and that nursing was to help as needed. Although the resident's care plan had been developed to care for the resident's personal hygiene needs, and had developed interventions to routinely clean the resident's room environment, the resident continued to have body odors and no new interventions were assessed or developed to protect and promote the resident's personal dignity.	F 241		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431		

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F 431	Continued From page 5 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to safely store medications by removing expired medications from use for resident stock supply in 1 of 1 stock medication cupboards. Findings include: During observations of medication storage on 11/13/13, at 9:35 a.m., five bottles of expired oyster shell calcium were noted stored in a stock medication cupboard, located in the facility's medication storage room. Two of the bottles had expiration dates of 12/2011, one had expired 2/2012, and the other two had expired 6/2012. Also noted in the stock medication cupboard was a bottle of robafen cough syrup, with an expiration date of 8/22/11, and a bottle of magnesium oxide, which did not identify an expiration date, but which was dated as having been opened on 8/10/11. On 11/13/13, at 9:35 a.m., registered nurse (RN)-A confirmed the above findings and confirmed the current facility policy. The director of nursing (DON) stated on 11/13/13,	F 431	All medications in the medication storage cupboard have had labels checked to assure proper labeling and no out dated expiration dates. Medications stored in other storage areas, med carts and medication fridge, have also been checked to assure no out dated meds. Procedure has been put in place to assure medications are removed from the storage cupboard and other storage areas, and properly disposed of when expired. Night nurse will clean, organize, monitor labels and expiration dates and complete medication storage log tracking form. Education will be provided to all licensed nursing staff on 12/17/13. Audit will be conducted weekly x 2 months then monthly with med destruction by DON or RN to assure compliance with new procedure. A summary of the results will be completed by DON and brought to the QA meeting for on-going compliance. Completion date 12/18/13.	

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F 431	Continued From page 6 at 9:35 a.m., that it was the night nurse's responsibility to go through the medication carts and cupboards, checking for expired and/or undated medications. The DON stated the night nurse would normally document when they had completed such checks. At 9:40 a.m. after reviewing the facility logs, the DON stated there was no documentation by a night nurse as to when the medication carts and medication room had last been checked. On 11/14/13 at 7:35 a.m. licensed practical nurse (LPN)-A stated the pharmacist had recently conducted the facility's monthly audit of the medication room and carts, and had not yet provided a list of any concerns related to the opened and/or expired medications in the medication room or carts. LPN-A stated the pharmacist usually provided the facility with documentation as to the results of the audit, but the 10/13 documentation was not found in the pharmacy book. The pharmacist who had conducted the review was on a medical leave and unavailable for interview. The facility's undated policy titled ID1: Storage of Medications section M, indicated outdated medications were to be "immediately removed from stock", disposed of according to medication disposal procedures and reordered.	F 431		
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced	F 505		

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F 505	Continued From page 7 by: Based on interview and document review, the facility failed to obtain and promptly notify the attending physician of laboratory results for 1 of 1 residents (R31) who received warfarin (blood thinner). Findings include: R31's diagnoses included atrial fibrillation (irregular heart beat). R31 received physician orders dated 10/13/13: #1. Increase warfarin to 8 mg by mouth tonight. Then 6 mg by mouth on Monday, Wednesday and Friday, and 4 mg by mouth on Sunday, Tuesday, Thursday, and Saturday. #2. Recheck INR (international normalization ratio - lab test to measure blood coagulation) in 1 week. Results to be sent to the ordering physician. No laboratory results were found in R31's documentation. During interview on 11/13/13, at 2:01 p.m. registered nurse (RN)-B confirmed the INR laboratory test results were not received, however, was able to determine the test was completed on 11/6/13. Following this interview RN-B made arrangements to receive the test results from the laboratory. RN-B confirmed the results should have been obtained and faxed to the physician more timely. During interview on 11/14/13, at 9:10 a.m. the director of nursing (DON) confirmed the INR laboratory test should not have taken more than 2 days for returned results. After 2 days the facility staff should have called to obtain the results and then faxed those results to the physician.	F 505		

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F 505	Continued From page 8 The policy dated 3/2013, titled Lab Policy, identified that laboratory tests were completed as soon as possible after receiving orders to ensure that medical interpretation and evaluation could be done within a reasonable length of time.	F 505	R31 lab results have been obtained and submitted to MD. All resident lab orders will be documented when ordered on a lab monitoring log. Log will contain the resident name, lab to be completed with date due, date results are received and faxed to MD for review and MD acknowledged received. RN will review dashboard on POC daily to assure new lab orders have been added to the Lab log and will review the lab log daily to assure lab has been completed as order and results received timely and faxed to MD for review. Education will be completed to all licensed nursing staff on 12/17/18. DON will audit lab log weekly to assure labs have been completed and faxed per procedure. Results of the audits will be summarized and brought to the QA meeting to assure ongoing compliance. Completion date 12/18/13.	

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

F5510023

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
	245510	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/13/2013

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM 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 YOU VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Evansville Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to:	K 000	POC ok JB 12-16-13	

DC: 12-25-13

EXIT: 11-15-13

RECEIVED
DEC 16 2013
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Admin Staff	12-12-13

r deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing 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 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

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K 000	Continued From page 1 Barbara.lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Evansville Care Center is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1968 and was determined to be of Type I(332) construction. In 1988, additions were added to the south of the Main Lounge and to the west of the North Wing that were determined to be of Type V(111) construction. In 1998 and addition was added to the end of West Wing that was determined to be of Type V(111) construction. Because the original building and the additions meet the construction types allowed for existing buildings, the facility was surveyed as one building. The facility is completely fire sprinkler protected. The facility has a fire alarm system with smoke detectors in the corridors and areas open to the corridors that is monitored for automatic fire department notification. The facility has a	K 000		

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K 000	Continued From page 2 capacity of 40 beds and had a census of 39 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain 1 of several smoke barrier walls construction that meet the requirements of NFPA 101 - 2000 edition, Sections 19-3.7.3 and 8.3. This deficient practice could affect 8 of 39 residents, staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 9:00 AM to 12:00 PM on 11/13/2012, observation revealed, that there was a penetration around the sprinkler pipe located behind the ceiling tiles above the East Wing	K 025		

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K 025	Continued From page 3 smoke barrier doors. This was confirmed by the Environmental Director (BT).	K 025	The penetration was sealed with fire barrier sealant on December 11, 2013. All penetrations through fire barrier walls will be sealed upon completion of the project. This will be inspected by the environmental services department and verified by the environmental services director.	