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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2NB3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00365

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245315**

2. STATE VENDOR OR MEDICAID NO. (L2) **541743100**

3. NAME AND ADDRESS OF FACILITY
(L3) **SEASONS HEALTHCARE**
(L4) **303 BROADWAY AVENUE SOUTH**
(L5) **TRIMONT, MN** (L6) **56176**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **01/30/2017** (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) **09/30**

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

12.Total Facility Beds **31** (L18)

13.Total Certified Beds **31** (L17)

10.THE FACILITY IS CERTIFIED AS:

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
	31			
(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 :
Susan Kalis, HFE NE II 02/07/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 02/07/2018 (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 **06/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245315

February 7, 2018

Ms. Patrice Goette, Administrator
Seasons Healthcare
303 Broadway Avenue South
Trimont, MN 56176

Dear Ms. Goette:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 18, 2018 the above facility is certified for:

31 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 31 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,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 7, 2018

Ms. Patrice Goette, Administrator
Seasons Healthcare
303 Broadway Avenue South
Trimont, MN 56176

RE: Project Number S5315027

Dear Ms. Goette:

On December 29, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 14, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 30, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on January 26, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 14, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 18, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 14, 2017, effective January 18, 2018 and therefore remedies outlined in our letter to you dated December 29, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Enclosure

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 7, 2018

Ms. Patrice Goette, Administrator
Seasons Healthcare
303 Broadway Avenue South
Trimont, MN 56176

Re: Reinspection Results - Project Number S5315027

Dear Ms. Goette:

On January 30, 2018 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 December 14, 2017, with orders received by you on January 4, 2018. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2NB3

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Facility ID: 00365

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2. STATE VENDOR OR MEDICAID NO. (L2) **541743100**

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(L3) **SEASONS HEALTHCARE**
(L4) **303 BROADWAY AVENUE SOUTH**
(L5) **TRIMONT, MN** (L6) **56176**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **12/14/2017** (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) **09/30**

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To (b) :

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___1. Acceptable POC

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	31			
(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 :
Wendy Dobie, HFE NE II 01/15/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 01/29/2018 (L20)

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

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

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B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 29, 2017

Ms. Patrice Goette, Administrator
Trimont Health Care Center
303 Broadway Avenue South
Trimont, MN 56176

RE: Project Number S5315027

Dear Ms. Goette:

On December 14, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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;

Electronic 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:

Holly Kranz, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato Place
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

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 January 23, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 23, 2018 the following remedy will be imposed:

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

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 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 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. 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 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.

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 March 14, 2018 (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 June 14, 2018 (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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

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
	245315	A. BUILDING _____ B. WING _____	12/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HEALTHCARE	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 12/11/17 through 12/14/17, during a recertification survey. The facility is not in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an emergency	E 001	Correction for all effective residents includes the completion of the facility	1/18/18

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

Electronically Signed | 01/04/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	12/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HEALTHCARE	**303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001	Continued From page 1 preparedness program, including a comprehensive all hazards approach to meet the health, safety, and security needs of the staff and patient population during an emergency or disaster situation. This had the potential to affect all 25 residents residing in the facility. Findings include: On 12/13/17, the administrator stated that the facility had not finished developing their emergency preparedness program, as the facility had been in a transition of ownership. The administrator stated the facility was working on finalizing the necessary procedures and staff training, now that the transition was complete. The Seasons Healthcare Major Disaster Plan, last reviewed on 12/4/17, contained a risk assessment but lacked the other required components of the disaster plan.	E 001	emergency preparedness plan. All residents have been identified as potentially being affected due to residing at the facility. The facility implemented an Emergency Preparedness Plan that includes a disaster/fire, lockdown/shelter in place, communication and evacuation plans, all in relation to the Hazard Vulnerability assessment that was completed in Nov. 2017 and reviewed in December 2017. The EP plan also addresses waste management, supplies, transportation, staffing needs and memo of understanding for off-site care. Letters were sent on 1/2/18 to all resident representatives regarding our EP Plan. The EP Plan will be communicated to residents that do not attend the meeting by having the plan communicated to them on a 1:1 visit by the Resident Life Coordinator by 1/12/18. Staff will be trained on the EP Plan at an all staff meeting on 1/11/18 including the completion of a table top exercise. Staff unable to attend will receive the written information to review and return a signature page stating they are aware of the Plan by 1/18/2018. The Plan will be monitored for effectiveness at each quarterly Quality Assurance Meeting and also following any incident/emergency in which the plan was utilized. The Hazard Vulnerability Assessment and entire EP Plan will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING _____ B. WING _____	12/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HEALTHCARE	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 001	Continued From page 2	E 001	reviewed annually by the Administrator.	
F 000	INITIAL COMMENTS 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 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the appropriate sized wheelchair for 1 of 1 resident (R16) reviewed for positioning. Findings include: During observation on 12/11/17 at 5:35 p.m., R16 was observed to be seated in a wheelchair (w/c) in the lounge area across from the nursing station. R16 was observed to be leaning against	F 558	An order was obtained on 12/13/17 for R16 for wheelchair/positioning evaluation by PT/OT. On 12/14/17 PT evaluated R16. Therapy placed R16 into a high back wheelchair. R16 stated he was comfortable in the chair. To identify other potential residents at risk for this deficiency a Mobility Device monitoring log was developed on 12/19/17.	12/19/17

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SEASONS HEALTHCARE	**303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176**

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F 558	Continued From page 3 the back of the w/c and the length of the chair seat extended only about halfway across the length of his thighs, and the top of the backrest reached only to R16's mid back. On 12/12/17, at 9:51 a.m., R16 was again observed seated in the same wheelchair, sleeping at intervals. As R16 dozed, his upper back was observed to be in a backwards leaning position, unsupported, and slightly over the top edge of the chair back. R16's head and neck were hyperextended and would bob up and down as he slept. During continued observations, R16 was noted to sleep at intervals, alternately resting his chin on his chest and hyperextending his head and neck back past the top of the w/c seat. On 12/13/17, at 8:49 a.m., R16 was observed to be seated in the same wheelchair. NA-B stated at that time, that R16 looked uncomfortable seated in a w/c that looked too small him. NA-B stated this concern had been brought up previously to nursing staff however added, "Nothing has been done". During interview on 12/13/17, at 9:11 a.m. the occupational therapist (OT) stated R16 would benefit from a larger wheelchair with an 18 inch depth, 20 inch width, and a high back because R16 was tall and his legs extended too far forward over the end of the wheelchair seat, and his back did not have adequate support. The OT verified there had been no assessment completed by therapy to determine the most appropriate sized wheelchair. During interview on 12/13/17, at 9:18 a.m. the director of nursing (DON) stated she relied on therapy to assess wheelchair seating, and stated	F 558	The Mobility Device Log consists of evaluating each resident on proper positioning and placement in their wheelchair, condition of their wheelchair, and other assistive devices. It also addresses those residents that are independent with their mobility. The Mobility Device Log will be completed/reviewed on a weekly basis following the weekly Medicare Meeting. This will be reviewed by the department managers and our contracted OT. Changes identified will be addressed based on the resident need (such as obtaining PT/OT evals, changing of equipment, etc.) following each meeting. The Mobility Device Log will be reviewed for effectiveness at each quarterly Quality Assurance Meeting.	

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F 558	Continued From page 4	F 558		

there should have been a therapy consult completed to assess R16's wheelchair positioning.

During further observation on 12/14/17 at 8:28 a.m., R16 was observed seated in his wheelchair beside the nursing station with his upper back, head and neck hyperextended back over the top of the chair while he dozed. R16's head and neck would drop back onto his shoulders, causing him to rouse and lift his head before going back to sleep.

During interview on 12/14/17 at 8:35 a.m., physical therapy assistant (PTA)-A stated R16's position appeared to be slouched with his head falling back, and stated there needed to be a precaution implemented to prevent potential tipping and to prevent neck discomfort. PTA-A then transported R16 to a high back chair in the lounge area and assisted him to transfer.

R16's clinical record lacked evidence of any therapy assessment related to proper wheelchair positioning prior to the recertification survey.

R16's face sheet indicated he'd been admitted to the facility on 4/7/16, with diagnoses including: functional urinary incontinence, cardiac pacemaker, long term use of anticoagulants, and diabetes mellitus.

A quarterly Minimum Data Set (MDS) assessment dated 10/10/17, indicated R16 had a Brief Interview for Mental Status(BIMS) score of 12/15, indicating moderate cognitive impairment. The same MDS indicated R16 required limited assistance for transfers, and extensive assistance for dressing, toileting and personal

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F 558	Continued From page 5 hygiene. R16's most recent care plan, didn't contain any interventions/recommendations for appropriate seating needs. Although requested, no policy was provided regarding wheelchair positioning.	F 558		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		1/11/18

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F 657	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a care plan was revised to address pressure ulcer risk and preventative measures for 1 of 1 resident (R5) reviewed for pressure ulcers. Findings include: R5's face sheet dated 12/14/17, identified current diagnoses of functional urinary incontinence, dementia without behavioral disturbance and chronic kidney disease. R5's admission Minimum Data Set (MDS) dated 10/23/17, did not identify any current pressure ulcers, so there was no care area assessment for pressure ulcer triggered. R5's most current care plan last revised 12/12/17, did not address R5's skin condition or any history of pressure ulcers. R5's Braden Scale (a tool used to assess pressure ulcer risk) dated 10/14/17, indicated a score of 22 (not at risk for pressure ulcers). R5's nursing progress notes dated 11/29/17, indicated R5 was noted to have an open area on his right buttock. The progress note indicated no drainage was coming from the site and a Duoderm dressing had been place. In addition, the note indicated R5's nurse practitioner was notified, and indicated R5 would be encouraged to lie down in bed rather than sleeping in his recliner. R5's Wound Flow Sheet dated 11/29/17,	F 657	Corrective action for R5 that was affected by this deficient practice was addressed on 12/15/17 by updating R5's plan of care to address his pressure ulcer risk by monitoring his risk for pressure ulcers related to decreased mobility. To identify other residents having the potential to be affected the MDS coordinator and DON audited all current resident care plans for history of risk of pressure ulcers and/or skin concerns on 12/15/17. No other residents were identified through this audit to be affected. On 12/26/17 a Care Plan Audit was developed that identifies new admissions at risk for pressure ulcers. The audit also addresses current residents who may have developed a pressure ulcer/skin concern or residents that are now using a new pressure relieving device. If the audit identifies any concerns the care plan is reviewed for appropriate problem, goal and intervention updates by the nursing staff. The audits will be completed by the Director of Nursing weekly and will be reviewed at the quarterly Quality Assurance meetings. Licensed nursing staff will be re-educated on 1/11/18 on the process of care planning for preventative measures regarding potential/history of pressure ulcers/skin concerns.	

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F 657	Continued From page 7	F 657		

indicated the resident had a superficial right buttock open area measuring 1 centimeter (cm) x 0.7 cm with a granulating wound base. The Flow Sheet indicated a Duoderm (a type of dressing used to treat pressure ulcers) had been applied, no drainage was coming from the site, and a fax was sent to R5's physician. Subsequent measurements on 12/3/17 and 12/10/17, indicated the wound decreased in size to 0.2 cm x 0.2 cm and was being monitored every day.

A Faxed Resident Update/Order Request form dated 11/29/17, included an order to change a Duoderm (a type of dressing used to treat pressure ulcers) to R5's right buttock every three days or as needed. R5 was noted to have an open area on his buttock. A clinic referral form with the same date, noted instructions by R5's physician to put a ROHO (a type of air-filled cushion which distributes pressure over bony prominences) in R5's recliner. The physician's clinic note also indicated R5 had a decubitus ulcer to the right gluteus.

R5's treatment administration records, dated 12/17 indicated R5's pressure ulcer was healed as of 12/12/17.

During observation on 12/13/17, at 10:42 a.m. R5 was noted to be ambulating by himself using a wheeled walker, and was able to transfer himself in and out of his recliner chair. R5 appeared neat and well-groomed.

During observation on 12/14/17, at 8:05 a.m. R5 was walking up and down the hallway with his wheeled walker following breakfast. R5 returned to his room, sat down in his recliner and appeared to have upright posture while seated.

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F 657	Continued From page 8 During interview on 12/14/17, at 8:57 a.m. R5 stated he'd had concerns with recurrent ulcers to his right buttock prior to admission while he was still living at home. R5 stated after he redeveloped the pressure ulcer on his buttock while in the nursing home, he was given a black cushion for his recliner to help distribute the pressure and stated, "More than anything, I think that helped." R5 was noted to have a black pressure redistribution cushion in the recliner at the time of the interview. R5 stated his pressure ulcer was currently resolved and the nurses did not need to apply a dressing. During interview on 12/14/17, at 10:03 a.m. licensed practical nurse (LPN)-A stated the floor nurses typically updated the resident care plans in between MDS assessments if a concern developed. The MDS Coordinator would then input any changes made on the paper copy, to the resident's computerized chart at the next assessment. LPN-A verified pressure ulcers and/or a risk for skin breakdown should have been addressed on the care plan for R5. During interview on 12/14/17, at 11:05 a.m. the director of nursing (DON) verified R5's care plan lacked any information about the pressure ulcer he'd had on his buttock, nor the risks for redevelopment. The DON said she would have expected whichever licensed nurse had noted the area to have initiated a new care plan problem with interventions. A policy regarding care planning and pressure ulcers was requested, none was provided.	F 657		
F 805	Food in Form to Meet Individual Needs	F 805		1/11/18

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F 805 SS=D	Continued From page 9 CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to prepare food in accordance with residetn needs for 2 of 2 residents (R7, R9) who were identified as on a mechanically altered (pureed) diet. Findings include: R7's signed physician orders dated 10/25/17, included the following diet order: NDD1 (National Dysphasia Diet Level 1) Puree and nectar thick liquids, NIP (nutrition intervention protocol) with meals. R9's signed physician orders dated 10/20/17, included the following diet order: Pureed-NIP with meals. On 12/11/17, at 6:12 p.m. cook-A was observed pureeing a grilled cheese sandwich for R7 and R9 for their supper meal. Cook-A placed the prepared grilled cheese into a food processor then added approximately 1/4 cups of water and blended the food. Cook-A then removed the cover from the food processor which revealed the pureed grilled cheese sandwich to be a soupy consistency. Cook-A stated she would be adding potato flakes to the mixture to thicken it up and give the food more flavor. Cook-A then added approximately 1/2- 1 cup of potato flakes to the	F 805	Corrective action for residents R7 & R9 - Dietary Manager reviewed with dietary cooks regarding current diet orders and policy and procedure of pureeing foods for the affected residents on 12/14/2017. No other potential residents were affected - only R7 & R9 are pureed diets. Dietary Manager will audit weekly the consistency of random pureed trays and process of pureeing. A competency audit checklist was developed on 12/15/2017 as part of the audit process. Dietary staff will be re-educated on 1/11/2018 on policy and procedure of pureeing foods. Audits will be reviewed with quarterly Quality Assurance meetings.	

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F 805	Continued From page 10	F 805		

mixure and processed until smooth. Cook-A dished up a portion of the grilled cheese/potato mixure for R7 and R9, heated in the microwave, then dished up a bowl of tomato soup for each of the residents. After dishing up the tomato soup, cook-A then added Thick-It food and beverage thickener to each resident's tomato soup prior to serving.

When interviewed on 12/13/17, at 7:41 a.m. cook-A stated there was no set amount of water to add when pureeing food and added she would just add enough water to cover the food. Cook-A confirmed routinely using water when pureeing food then thickening with the potato flakes. Cook-A further confirmed thickening both R7 and R9's tomato soup prior to serving.

When interviewed on 12/14/17, at 12:18 p.m. the dietary manager (DM) stated it would be ok to add a small amount of flake mashed potatoes to a pureed grilled cheese sandwich. However, the DM further stated she would have expected staff to puree the sandwiches using a small amount of hot water so the mixture didn't get to be too soupy or too pasty. The DM confirmed thickener would not need to be added to R9's tomato soup as the resident didn't require thickened liquids.

When interviewed on 12/14/17, at 1:58 p.m. the registered dietician (RD) recommended not using water when pureeing food as it would dilute the food and lose nutritional value. RD confirmed R9 would not require tomato soup to be thickened as the resident did not have an order for thickened liquids.

The undated policy and procedure titled, Method of Pureeing Food, included the following: 2.

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F 805	Continued From page 11 Place desired number of portions into food processor or blender. 3. Add milk, broth or other liquid as needed for product consistency (usually 2-3 TBSP). Never puree with water.	F 805		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		1/11/18

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F 880	Continued From page 12 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure urine specimens were stored in a sanitary manner, separate from resident medications. This deficient practice had the potential to affect 3 residents (R11, R17, R18)	F 880	Corrective action for residents R11, R17 and R18 - On 12/11/17 the urine specimen was discarded. No other residents were affected - only	

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F 880	Continued From page 13 who had medications stored in the same refrigerator as a urine sample. Findings include: During observation on 12/11/17, at 2:39 p.m. a mini-fridge used to store resident refrigerated medications was also observed to contain a urine sample dated 12/8/17, that was awaiting transport to the laboratory. The urine sample was stored in a plastic urinalysis cup inside of a plastic bag. The refrigerator was observed to contain overflow resident medications, eye drops and insulin pens for residents R11, R17 and R18. The refrigerator contained one bottle of Latanoprost eye drops, five Lantus insulin pens, three Trujeo insulin pens. During interview on 12/11/17, at 2:43 p.m. registered nurse-B stated the facility routinely used the medication refrigerator for storing urine specimens, "Unfortunately, that is what we have [to store specimens]." During interview on 12/14/17, at 10:05 a.m. the director of nursing (DON) confirmed the resident medication refrigerator was being used to store the urine samples awaiting transport to a laboratory. The DON verified the urine samples should probably be stored in their own refrigerator. Policies related to handling of urine specimens and storage were requested however, none were provided.	F 880	medications for R11, R17 & R18 had medications in that refrigerator. A cooler was purchased and brought into the facility on 12/12/2017 for the purpose of storing all specimens. The cooler is stored in the soiled utility room. All licensed nurses were educated on the correct storage of specimens. A policy and procedure was developed on 1/4/18 and reviewed with nurses on 1/5/18 and reviewed at all staff meeting on 1/11/18. The DON will do random audits on the storage of specimens and audits will be reviewed at the quarterly Quality Assurance meetings.	
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i)	F 921		1/11/18

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F 921	Continued From page 14 §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the environment in a clean and sanitary method for flooring in resident rooms and bathrooms, for 5 of 19 resident rooms observed (Rooms 117, 118, 119, 120 & 121) and failed to ensure wheelchairs were maintained in a state of good repair, for 2 of 2 resident wheelchairs (R2 & R8) observed to be in a state of disrepair with arm coverings being torn. Findings include: During an environmental tour on 12/14/17, at 10:44 a.m. with the maintenance supervisor (MS) and housekeeping supervisor (HS) the following observations were noted: The bathroom floor in room 117 was observed to be soiled with brown stains, and there was dirt buildup around the base of the toilet. There was also a large gap between the edge of the flooring and the base of the toilet. The base boards beside the toilet and extending behind the toilet, and beneath the sink, was observed to have a 1/8 inch seam with a heavy buildup of dirt and dust. In the bedroom area of 117, there was a buildup of dust and dirt in the corners and under the chair located on the wall beside the window. Both the MS and HS observed the buildup of dirt/dust and stated this should have been cleaned when daily housekeeping services were conducted.	F 921	Corrective action for affected residents in rooms 117, 118. 119, 120 & 121 - Housekeeping Supervisor met with housekeepers in the resident rooms and showed them the areas of concern and the areas were cleaned at that time on 12/14/17. Potential for all residents to be affected due to inadequate housekeeping. Our plan to correct this deficiency is that all resident bathroom floors will be cleaned appropriately by 1/5/2018. Education provided to housekeeping staff on appropriate cleaning methods and cleaner to use on 12/14/17 by the Housekeeping Supervisor. The Housekeeping Supervisor developed an Environmental Checklist to be used as a weekly audit. Audits will be reviewed at quarterly Quality Assurance meetings. Education will be reviewed again at all staff meeting on 1/11/18. Corrective action for R2 and R8 regarding disrepair of arm coverings on their wheelchairs - arm coverings were ordered and replaced on 12/14/2017 and 1/3/18. Other residents affected were identified	

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	245315	A. BUILDING _____ B. WING _____	12/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HEALTHCARE	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

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F 921	Continued From page 15 The shared bathroom between rooms 118 and 119, was observed to have a dark brown substance extending 1/8 inch from the base of the toilet, along the baseboard beside the toilet, and extending behind and under the sink areas. In addition, there were brown spots on the flooring in front of and beside the toilet. The base board and door on the room 118's side contained scrapes and gouges extending into the surfaces. The flooring of the bathroom for room 120, was stained with a brownish buildup of dust and dirt around the base of the toilet, and brown spots on the floor and beside the toilet. The baseboard extending beside the toilet, as well as behind the toilet and under the sink, was observed to be soiled with dirt and dust, and there was a buildup of dirt in the corner. The area under the heat register in the bathroom was also noted to have a heavy build up of dust and dirt under it. In the bedroom area of 120, there was dust and dirt build up observed beneath the table and chair. R2 was present in the room, and verified these areas of the room had not been cleaned. R2 stated she would have done it herself, but she was not supposed to get down on the floor. Room 121, vacant after a resident had been discharged on 12/11/17, was observed to have dirt and dust build up in the corners, and the bathroom baseboard areas were soiled with a dirt/dust build up. Although staff had indicated the room was ready for a new admit, the MS confirmed the room required additional cleaning. During the environmental tour, the MS stated there were no regular audits to ensure resident	F 921	on 12/19/17 through the use of our Mobility Device Log. Arm coverings were ordered and replaced on 1/4/18 by the Maintenance Director. Monitoring for condition of mobility devices will be reviewed weekly with the Mobility Device Log meeting and appropriate repairs will completed as needed. The Mobility Device Log effectiveness regarding identifying disrepair will be reviewed at quarterly Quality Assurance meetings. All staff will also be reeducated on the use of the Maintenance Repair Log to assist in identifying disrepair of items on 1/11/18.	

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F 921	Continued From page 16 rooms/bathrooms were clean and in good repair, and verified this was an area they would need to work on in the future. During observations throughout the course of the survey from 12/11-12/14/17, R2 and R8 were observed to sit in wheelchairs where the vinyl covering was missing from the wheelchair arms. Foam padding was exposed, and the wheelchair arms no longer had a cleanable surface. During observation and interview on 12/14/17, at 10:50 a.m. the MS indicated he had not been notified the wheelchairs required repair, and stated he depended on nursing to notify him when there was a need for equipment repairs. At that time, the MS confirmed there was no process currently in place to assess the need for repairs, but indicated he would work on implementing one in the future.	F 921		

Electronically delivered
December 29, 2017

Ms. Patrice Goette, Administrator
Trimont Health Care Center
303 Broadway Avenue South
Trimont, MN 56176

Re: State Nursing Home Licensing Orders - Project Number S5315027

Dear Ms. Goette:

The above facility was surveyed on December 11, 2017 through December 14, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyor's findings are

the Suggested Method of Correction and the Time Period for Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Holly Kranz at 507-344-2742 or at holly.kranz@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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,

Kamala Fiske-Downing

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

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
	00365	A. BUILDING: _____ B. WING _____	12/14/2017

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SEASONS HEALTHCARE	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 12/11, 12/12, 12/13 and 12/14/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

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2 000	Continued From page 2 APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a care plan was developed to address pressure ulcer risk and preventative measures for 1 of 1 resident (R5) reviewed for pressure ulcers. Findings include: R5's face sheet dated 12/14/17, identified current diagnoses of functional urinary incontinence, dementia without behavioral disturbance and chronic kidney disease.	2 570	Corrected	1/11/18

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2 570	Continued From page 3 R5's admission Minimum Data Set (MDS) dated 10/23/17, did not identify any current pressure ulcers, so there was no care area assessment for pressure ulcer triggered. R5's most current care plan last revised 12/12/17, did not address R5's skin condition or any history of pressure ulcers. R5's Braden Scale (a tool used to assess pressure ulcer risk) dated 10/14/17, indicated a score of 22 (not at risk for pressure ulcers). R5's nursing progress notes dated 11/29/17, indicated R5 was noted to have an open area on his right buttock. The progress note indicated no drainage was coming from the site and a Duoderm dressing had been place. In addition, the note indicated R5's nurse practitioner was notified, and indicated R5 would be encouraged to lie down in bed rather than sleeping in his recliner. R5's Wound Flow Sheet dated 11/29/17, indicated the resident had a superficial right buttock open area measuring 1 centimeter (cm) x 0.7 cm with a granulating wound base. The Flow Sheet indicated a Duoderm (a type of dressing used to treat pressure ulcers) had been applied, no drainage was coming from the site, and a fax was sent to R5's physician. Subsequent measurements on 12/3/17 and 12/10/17, indicated the wound decreased in size to 0.2 cm x 0.2 cm and was being monitored every day. A Faxed Resident Update/Order Request form dated 11/29/17, included an order to change a Duoderm (a type of dressing used to treat pressure ulcers) to R5's right buttock every three	2 570		

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2 570	Continued From page 4 days or as needed. R5 was noted to have an open area on his buttock. A clinic referral form with the same date, noted instructions by R5's physician to put a ROHO (a type of air-filled cushion which distributes pressure over bony prominences) in R5's recliner. The physician's clinic note also indicated R5 had a decubitus ulcer to the right gluteus. R5's treatment administration records, dated 12/17 indicated R5's pressure ulcer was healed as of 12/12/17. During observation on 12/13/17, at 10:42 a.m. R5 was noted to be ambulating by himself using a wheeled walker, and was able to transfer himself in and out of his recliner chair. R5 appeared neat and well-groomed. During observation on 12/14/17, at 8:05 a.m. R5 was walking up and down the hallway with his wheeled walker following breakfast. R5 returned to his room, sat down in his recliner and appeared to have upright posture while seated. During interview on 12/14/17, at 8:57 a.m. R5 stated he'd had concerns with recurrent ulcers to his right buttock prior to admission while he was still living at home. R5 stated after he redeveloped the pressure ulcer on his buttock while in the nursing home, he was given a black cushion for his recliner to help distribute the pressure and stated, "More than anything, I think that helped." R5 was noted to have a black pressure redistribution cushion in the recliner at the time of the interview. R5 stated his pressure ulcer was currently resolved and the nurses did not need to apply a dressing.	2 570		

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2 570	Continued From page 5 During interview on 12/14/17, at 10:03 a.m. licensed practical nurse (LPN)-A stated the floor nurses typically updated the resident care plans in between MDS assessments if a concern developed. The MDS Coordinator would then input any changes made on the paper copy, to the resident's computerized chart at the next assessment. LPN-A verified pressure ulcers and/or a risk for skin breakdown should have been addressed on the care plan for R5. During interview on 12/14/17, at 11:05 a.m. the director of nursing (DON) verified R5's care plan lacked any information about the pressure ulcer he'd had on his buttock, nor the risks for redevelopment. The DON said she would have expected whichever licensed nurse had noted the area to have initiated a new care plan problem with interventions. A policy regarding care planning and pressure ulcers was requested, none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan is revised for each resident. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure care plans are current and up to date. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must	2 830		12/19/17

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2 830	Continued From page 6 receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the appropriate sized wheelchair for 1 of 1 resident (R16) reviewed for positioning. Findings include: During observation on 12/11/17 at 5:35 p.m., R16 was observed to be seated in a wheelchair (w/c) in the lounge area across from the nursing station. R16 was observed to be leaning against the back of the w/c and the length of the chair seat extended only about halfway across the length of his thighs, and the top of the backrest reached only to R16's mid back. On 12/12/17, at 9:51 a.m., R16 was again observed seated in the same wheelchair, sleeping at intervals. As R16 dozed, his upper back was observed to be in a backwards leaning position, unsupported, and slightly over the top edge of the chair back. R16's head and neck were hyperextended and would bob up and down	2 830	Corrected	

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2 830	Continued From page 7 as he slept. During continued observations, R16 was noted to sleep at intervals, alternately resting his chin on his chest and hyperextending his head and neck back past the top of the w/c seat. On 12/13/17, at 8:49 a.m., R16 was observed to be seated in the same wheelchair. NA-B stated at that time, that R16 looked uncomfortable seated in a w/c that looked too small him. NA-B stated this concern had been brought up previously to nursing staff however added, "Nothing has been done". During interview on 12/13/17, at 9:11 a.m. the occupational therapist (OT) stated R16 would benefit from a larger wheelchair with an 18 inch depth, 20 inch width, and a high back because R16 was tall and his legs extended too far forward over the end of the wheelchair seat, and his back did not have adequate support. The OT verified there had been no assessment completed by therapy to determine the most appropriate sized wheelchair. During interview on 12/13/17, at 9:18 a.m. the director of nursing (DON) stated she relied on therapy to assess wheelchair seating, and stated there should have been a therapy consult completed to assess R16's wheelchair positioning. During further observation on 12/14/17 at 8:28 a.m., R16 was observed seated in his wheelchair beside the nursing station with his upper back, head and neck hyperextended back over the top of the chair while he dozed. R16's head and neck would drop back onto his shoulders, causing him to rouse and lift his head before going back to sleep.	2 830		

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2 830	Continued From page 8 During interview on 12/14/17 at 8:35 a.m., physical therapy assistant (PTA)-A stated R16's position appeared to be slouched with his head falling back, and stated there needed to be a precaution implemented to prevent potential tipping and to prevent neck discomfort. PTA-A then transported R16 to a high back chair in the lounge area and assisted him to transfer. R16's clinical record lacked evidence of any therapy assessment related to proper wheelchair positioning prior to the recertification survey. R16's face sheet indicated he'd been admitted to the facility on 4/7/16, with diagnoses including: functional urinary incontinence, cardiac pacemaker, long term use of anticoagulants, and diabetes mellitus. A quarterly Minimum Data Set (MDS) assessment dated 10/10/17, indicated R16 had a Brief Interview for Mental Status(BIMS) score of 12/15, indicating moderate cognitive impairment. The same MDS indicated R16 required limited assistance for transfers, and extensive assistance for dressing, toileting and personal hygiene. R16's most recent care plan, didn't contain any interventions/recommendations for appropriate seating needs. Although requested, no policy was provided regarding wheelchair positioning. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures	2 830		

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SEASONS HEALTHCARE	303 BROADWAY AVENUE SOUTH TRIMONT, MN 56176

(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) COMPLETE DATE
2 830	Continued From page 9 related to ensuring resident needs are met to provide appropriately fitted wheelchairs. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure resident's are provided with wheelchairs that fit them appropriately. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of	21390		1/11/18

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21390	Continued From page 10 current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure urine specimens were stored in a sanitary manner, separate from resident medications. This deficient practice had the potential to affect 3 residents (R11, R17, R18) who had medications stored in the same refrigerator as a urine sample. Findings include: During observation on 12/11/17, at 2:39 p.m. a mini-fridge used to store resident refrigerated medications was also observed to contain a urine sample dated 12/8/17, that was awaiting transport to the laboratory. The urine sample was stored in a plastic urinalysis cup inside of a plastic bag. The refrigerator was observed to contain overflow resident medications, eye drops and insulin pens for residents R11, R17 and R18. The refrigerator contained one bottle of Latanoprost eye drops, five Lantus insulin pens, three Trujeo insulin pens. During interview on 12/11/17, at 2:43 p.m. registered nurse-B stated the facility routinely used the medication refrigerator for storing urine specimens, "Unfortunately, that is what we have [to store specimens]." During interview on 12/14/17, at 10:05 a.m. the director of nursing (DON) confirmed the resident medication refrigerator was being used to store the urine samples awaiting transport to a	21390	Corrected	

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21390	Continued From page 11 laboratory. The DON verified the urine samples should probably be stored in their own refrigerator. Policies related to handling of urine specimens and storage were requested however, none were provided. SUGGESTED METHOD OF CORRECTION: The director of nursing and or designees could review infection control practices for safe storage of specimens of body fluids, and revise facility procedures and policies as necessary. The director of nursing could complete audits of safe practices and staff competency to ensure infection control guidelines are followed, and could educate staff with respect to any policy changes. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to maintain the environment in a clean and sanitary method for flooring in resident rooms	21685	Corrected	1/11/18

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21685	Continued From page 12	21685		

and bathrooms, for 5 of 19 resident rooms observed (Rooms 117, 118, 119, 120 & 121) and failed to ensure wheelchairs were maintained in a state of good repair, for 2 of 2 resident wheelchairs (R2 & R8) observed to be in a state of disrepair with arm coverings being torn.

Findings include:

During an environmental tour on 12/14/17, at 10:44 a.m. with the maintenance supervisor (MS) and housekeeping supervisor (HS) the following observations were noted:

The bathroom floor in room 117 was observed to be soiled with brown stains, and there was dirt buildup around the base of the toilet. There was also a large gap between the edge of the flooring and the base of the toilet. The base boards beside the toilet and extending behind the toilet, and beneath the sink, was observed to have a 1/8 inch seam with a heavy buildup of dirt and dust.

In the bedroom area of 117, there was a buildup of dust and dirt in the corners and under the chair located on the wall beside the window. Both the MS and HS observed the buildup of dirt/dust and stated this should have been cleaned when daily housekeeping services were conducted.

The shared bathroom between rooms 118 and 119, was observed to have a dark brown substance extending 1/8 inch from the base of the toilet, along the baseboard beside the toilet, and extending behind and under the sink areas. In addition, there were brown spots on the flooring in front of and beside the toilet. The base board and door on the room 118's side

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21685	Continued From page 13	21685		

contained scrapes and gouges extending into the surfaces.

The flooring of the bathroom for room 120, was stained with a brownish buildup of dust and dirt around the base of the toilet, and brown spots on the floor and beside the toilet. The baseboard extending beside the toilet, as well as behind the toilet and under the sink, was observed to be soiled with dirt and dust, and there was a buildup of dirt in the corner. The area under the heat register in the bathroom was also noted to have a heavy build up of dust and dirt under it.

In the bedroom area of 120, there was dust and dirt build up observed beneath the table and chair. R2 was present in the room, and verified these areas of the room had not been cleaned. R2 stated she would have done it herself, but she was not supposed to get down on the floor.

Room 121, vacant after a resident had been discharged on 12/11/17, was observed to have dirt and dust build up in the corners, and the bathroom baseboard areas were soiled with a dirt/dust build up. Although staff had indicated the room was ready for a new admit, the MS confirmed the room required additional cleaning.

During the environmental tour, the MS stated there were no regular audits to ensure resident rooms/bathrooms were clean and in good repair, and verified this was an area they would need to work on in the future.

During observations throughout the course of the survey from 12/11-12/14/17, R2 and R8 were observed to sit in wheelchairs where the vinyl covering was missing from the wheelchair arms.

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21685	Continued From page 14 Foam padding was exposed, and the wheelchair arms no longer had a cleanable surface. During observation and interview on 12/14/17, at 10:50 a.m. the MS indicated he had not been notified the wheelchairs required repair, and stated he depended on nursing to notify him when there was a need for equipment repairs. At that time, the MS confirmed there was no process currently in place to assess the need for repairs, but indicated he would work on implementing one in the future. SUGGESTED METHOD OF CORRECTION: The administrator or designee could conduct periodic audits of resident rooms and equipment, to ensure they are clean and in good working condition. The administrator or designee could report findings of the audit to the quality assurance committee for recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Trimont Health Care Center was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 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 By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/04/2018

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 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. Trimont Healthcare Center was constructed as follows: The original building was constructed in 1963, is one-story, has a partial basement, is fully sprinklered and was determined to be of Type II(222) construction; The 1992 Chapel Addition is one-story, has no basement, is fully sprinklered and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. All Resident Rooms are equipped with single-station, battery-operated smoke alarms. The facility has a capacity of 31 beds and had a census of 26 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to be in accordance with Chapter 7, which states, all means of egress is to be continuously maintained free of all obstructions to full use in case of emergency. This deficient practice could affect 24 of the 24 residents. Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 12/12/2017, obersvation revealed a plant decoration was observed in the "Time Clock" egress stairwell from the lower level.	K 211	Corrective Action - the plant decoration observed in the Time Clock egress stairwell was removed on 12/12/17. The Maintenance Director will monitor for items in the means of egress and remove them as found.	12/12/17

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K 211	Continued From page 3 This deficient practice was verified by the Facility Maintenance Director.	K 211		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to ensure that fire sprinklers were kept from obstructions that could effect the operation in accordance with NFPA 13. This deficient practice could affect 24 of the 24 residents. Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in	K 351	Wires were relocated and cable ties were removed from fire sprinkler pipe on 12/13/2017. The rest of the sprinkler pipes were inspected to ensure there were no other obstructions on 12/13/17. The Maintenance director will monitor for items attached or near the fire sprinkler pipes and remove as found.	12/13/17

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K 351	Continued From page 4 accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 12/12/2017, observation revealed wires and cables attached to the fire sprinkler pipe in the lower level generator room. This deficient practice was verified by the Facility Maintenance Director.	K 351		
K 912 SS=E	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.4.2 (NFPA 99)	K 912		1/12/18

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K 912	Continued From page 5 This REQUIREMENT is not met as evidenced by: Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.4.2 (NFPA 99) This deficient practice could affect 26 of 26 residents. Findings include: On facility tour between 10:00 AM and 1:00 PM on 12/12/2017, documentation could not be located to show that an electrical outlet inspection had occurred throughout the facility. These deficient practices were verified by the Facility Maintenance Director.	K 912	The Maintenance Director obtained the Electrical Outlet testing equipment and form and will perform the inspection on all resident rooms, bathrooms and common areas accessible by residents and document findings. This inspection will be conducted and completed by the Maintenance Director by 1/12/18. The Maintenance Director will conduct this testing annually and monitor for appropriate grounding of outlets.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for	K 920		1/2/18

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SEASONS HEALTHCARE	**303 BROADWAY AVENUE SOUTH** **TRIMONT, MN 56176**

(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 920	Continued From page 6 PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to comply with 10.2.4 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5.This deficient practice could affect 26 of the 26 residents. Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure.	K 920	A certified electrician was contacted and installed an outlet for the sump pump in the boiler room on 1/2/2018. The extension cord was removed. The Maintenance Director will monitor for use of extension cords when he does his weekly walk through of the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245315	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/12/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS HEALTHCARE	**303 BROADWAY AVENUE SOUTH** **TRIMONT, MN 56176**

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K 920	Continued From page 7 Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 12/12/2017, an extension cord was observed being used as a source of fixed wiring in the boiler room. A sump pump was plugged into a extension cord. This deficient practice was verified by the Facility Maintenance Director.	K 920		