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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2WXQ

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00936

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245319**

2.STATE VENDOR OR MEDICAID NO.
(L2) **486728900**

3. NAME AND ADDRESS OF FACILITY
(L3) **LA CRESCENT HEALTH SERVICES**
(L4) **101 SOUTH HILL STREET**
(L5) **LA CRESCENT, MN** (L6) **55947**

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) **04/01/2006**

6. DATE OF SURVEY **11/15/2017** (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)
**12/31**

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:

___1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

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

* Code: **A,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | **45** | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

**See Attached Remarks**

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud, HFE-NE II 12/4/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/4/2017 (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
**07/01/1986**
(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.
**00454**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN- 245319

Documentation supporting the facility's request for a continuing waiver involving LSC K521 is being recommended and forwarded to CMS for approval.

CMS Certification Number (CCN): 245319

December 6, 2017

Ms. Abby Rand, Administrator
La Crescent Health Services
101 South Hill Street
La Crescent, MN 55947

Dear Ms. Rand:

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 October 24, 2017 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

Your request for waiver of K67 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Program.

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

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

Please contact me if you have any 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

Electronically delivered
November 20, 2017

Ms. Anna Hanson, Administrator
La Crescent Health Services
101 South Hill Street
La Crescent, MN 55947

RE: Project Number F5319026

Dear Ms. Hanson:

On September 28, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 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 October 24, 2017, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 14, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 24, 2017. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on September 14, 2017.

However, compliance with the health deficiencies issued pursuant to the September 14, 2017 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 14, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective December 14, 2017. They will also notify the State Medicaid Agency that they

must also deny payment for new Medicaid admissions effective December 14, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, La Crescent Health Services is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 14, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

## APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 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.

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

Electronically delivered

December 6, 2017

Ms. Abby Rand, Administrator
La Crescent Health Services
101 South Hill Street
La Crescent, MN 55947

RE: Project Number S5319026

Dear Ms. Rand:

On November 20, 2017, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 14, 2017. (42 CFR 488.417 (b))

Also, we notified you in our letter of October 20, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 14, 2017.

This was based on the deficiencies cited by this Department for a standard survey completed on September 18, 2017, and lack of verification of substantial compliance with the health deficiencies at the time of our November 20, 2017 notice. The most serious deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On November 15, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 18, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 24, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 18, 2017, as of October 24, 2017.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following action related to the remedy outlined in our letter of November 20, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these action:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 14, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective December 14, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective December 14, 2017, is to be rescinded.

In our letter of November 20, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 14, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 24, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Your request for a continuing waiver involving the deficiency cited under K521 at the time of the September 18, 2017 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR 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

cc: Licensing and Certification File

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** ID: 2WXQ

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY** Facility ID: 00936

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245319**
2.STATE VENDOR OR MEDICAID NO.
(L2) **486728900**

3. NAME AND ADDRESS OF FACILITY
(L3) **LA CRESCENT HEALTH SERVICES**
(L4) **101 SOUTH HILL STREET**
(L5) **LA CRESCENT, MN** (L6) **55947**

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) **04/01/2006**

6. DATE OF SURVEY **09/14/2017** (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)
**12/31**

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

12.Total Facility Beds **45** (L18)
13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___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)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room
* Code: **B,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | **45** | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
**See Attached Remarks**

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud, HFE-NE II 10/17/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 10/25/2017 (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
**07/01/1986**
(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.
**00454**
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

On September 14, 2017, a standard survey was completed at the facility by the Minnesota Department of Health and Public Safety to determine if the facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and Medicaid programs. This survey found the most serious deficiency in the facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S F), whereby corrections are required. The facility has been given an opportunity to correct before remedies would be imposed.

Documentation supporting the facility's request for an annual waiver of the following life safety code deficiencies have been forwarded to the CMS Region V Office for its determination:

K521 – HVAC 42 CFR 483.70(a) NFPA Life Safety Code Standard

Approval of the waiver request has been recommended.

Refer to the CMS 2567 forms for both health and life safety code along with the facility's plan of correction, and CMS 2786R Provision Number K84 justification page.

Electronically delivered September 28, 2017

Ms. Abby Rand, Administrator
La Crescent Health Services
101 South Hill Street
La Crescent, MN 55947

RE: Project Number S5319026

Dear Ms. Rand:

On September 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 attached 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:

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

## 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 October 24, 2017, 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 October 24, 2017 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 December 14, 2017 (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 March 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,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

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 |
|---|---|---|---|
| | 245319 | A. BUILDING _____ B. WING _____ | 09/14/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LA CRESCENT HEALTH SERVICES | 101 SOUTH HILL STREET LA CRESCENT, MN 55947 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>On September 11, 12, 13, & 14, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.<br><br>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.<br><br>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 242 SS=D | 483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES<br><br>(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the | F 242 | | 10/24/17 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 10/10/2017 |

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

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| F 242 | Continued From page 1<br>facility.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to comprehensively assess and implement bathing choices for 1 of 1 resident (R49) reviewed for choices.<br><br>Findings include:<br><br>R49's admission minimum data set (MDS) dated 7/12/17, identified R49 had been interviewed and identified being able to choose between shower, bed bath or sponge bath to be, "very important." Further it had identified R49's cognition is intact and needs 1 person physical assist with bathing.<br><br>During interview on 9/11/17, at 7:13 p.m., R49 stated she was never offered a bath at any time from admission to now, and states she would prefer a bath.<br><br>During interview on 9/12/17, at 1:48 p.m., nursing assistant, (NA)-A stated she didn't think a resident had ever been asked if they wanted a bath and didn't think the residents even knew they had a tub. NA-A also stated she had worked here for a year and a half and had always given the residents showers. NA-A further stated she doesn't know how to work the tub and that she didn't want to offer a resident a bath if she doesn't know how to work the tub.<br><br>During interview on 9/12/17, at 1:51 p.m., NA-B stated she has worked here for 4 months and has never been shown how to work the tub. NA-B further stated, "I have always wondered why we didn't use it [tub], some of the residents would probably like to soak in the tub." | F 242 | R2 was interviewed regarding bathing preference. She prefers to continue with showers at this time.<br><br>All residents have the potential to be affected if bathing preferences are not offered. All residents have been interviewed regarding preference for bathing. Preferences will be followed for all residents and reviewed during care conferences.<br><br>Nursing staff have been educated on following bathing preferences. Preferences for bathing have been added to CNA care sheets. CNA's have been trained on operation of the tub for bathing.<br><br>DON/designee will complete audits on following bathing preferences weekly x 4 weeks then monthly x 2 months. Negative findings will be corrected immediately. Results will be communicated to facility QAPI committee.<br><br>Completion date 10/24/17 | |

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| F 242 | Continued From page 2<br><br>During interview on 9/12/17, at 1:59 p.m., NA-C stated she had worked here for about 5 years and does not know how to work the tub and also stated no resident here uses the tub. NA-C further verified the current bath schedule does not show whether a resident gets a bath or a shower and that everyone here gets a shower.<br><br>During interview on 9/12/17, at 2:04 p.m., director of nursing (DON) stated none of the residents currently use the bath tub right now. DON further stated, "I never really thought much about a follow up on choices for a bath versus a shower."<br><br>A policy for bathing preferences was requested and the DON verified they did not have a policy regarding resident preferences. | F 242 | | |
| F 253 SS=E | 483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to provide comfortable interior bedroom temperatures during the winter months due to aging/ill fitting windows according to 2 of 2 residents (R2, R15, and R11) who complained about cold air coming through the windows in their rooms. This had the potential to affect most residents in the facility during the winter months in the 30 resident rooms available for occupancy.<br><br>Findings include: | F 253 | R2, R11, and R15 windows have been assessed and potential leaks have been repaired.<br><br>All residents have the potential to be affected if temperatures are not maintained at a comfortable level. Windows in resident rooms have been assessed and potential leaks have been repaired as necessary to ensure proper temperatures are maintained. | 10/24/17 |

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| F 253 | Continued From page 3<br><br>R2 was interviewed on 9/11/17, at 6:49 p.m. in regards to comfortable temperatures in the facility. R2 stated it gets cold in the room during the winter due to cold air coming through the windows. R2 went on to state the current windows had not been replaced since the building was built in 1969, and at times when it really gets cold he uses 5 or 6 blankets to keep warm. R2 stated it has been cold in the room during the winter for the past three years he has been at the facility.<br><br>R2 was again interviewed on 9/14/17, at 12:54 p.m. regarding his concern with cold temperatures in the room during the winter. R2 stated in the winter there is a "hell of a breeze coming in." R2 said he had spoken with staff every year about the cold that comes in through the windows and had never received a satisfactory response.<br><br>R2's room was observed on 9/11/17, at 6:50 p.m., and there were shims (thin or wedged piece) were placed under the aluminum single-paned window in R2's room. The wood frame under the window was crumbling and the window was loose in the frame so the wedge was used to keep the window in place.<br><br>R15 was interviewed on 9/11/17, at 3:13 p.m. and asked about comfortable temperatures in the facility. R15 stated my room is cold in the winter and the windows "rattle like crazy."<br><br>R15's room was observed on 9/14/17, at 12:38 p.m. it was noted that the single-paned aluminum window was loose in the frame. | F 253 | Maintenance staff has been educated on monitoring and maintaining comfortable room temperatures and repairing potential leaks in windows.<br><br>ED will audit temperature levels in 5 resident rooms weekly x 4 weeks then monthly x 2 months. Temperatures out of range will be addressed immediately. Results will be communicated to facility QAPI.<br><br>Completion date 10/24/17 | |

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| F 253 | Continued From page 4 | F 253 | | |

R11's family member (FM-A) was interview on 9/12/17, at 8:47 a.m. and asked about comfortable temperatures in the facility regarding R11's preference. FM-A stated that R11 had been a resident at the facility since 2010 and that it was cold in the facility every winter. FM-A said that she asked brought the cold room during the winter before admitting her loved one (R11) and the facility had "promised" that they would be getting new windows, along with a new roof, and that "nothing has ever been done" as the windows continue to be a problem by letting cold air in the room.

During an interview on 9/14/17, at 12:31 p.m. with maintenance (M)-B regarding the cold air that comes through/around the resident windows during the winter. M-B stated, "They [resident room windows] all suck." M-B stated he had used plastic to cover the inside of the windows in the past but was told that was no longer possible due to the plastic ripping and being a possible fire hazard. Last year M-B stated he used spray foam to try to minimize the leaking of frigid air into the rooms, along with plastic on the outside of the windows. But this was not fully affective. M-B stated the shims were in place to attempt to stabilize the window in R2's room because the facility is built on a floating cement slab so it shifts. M-B went on to state that he had requested new windows for the past 40 years because the current aluminum framed windows conducts cold and during the winter there is such a loss of heat that the facility does not have snow for approximately 2 feet from the building. M-B did verify that the windows were loose and ill fitting and did rattle when it was windy.

During an interview on 9/14/17, at 1:13 p.m. with

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| F 253 | Continued From page 5<br>the administrator regarding the cold resident rooms throughout the facility. The administrator said that they have requested to have the resident room windows replaced as a priority. The administrator said she would submit another requisition for replacement of the windows to promote resident comfort when in their rooms.<br><br>A policy was requested in regards to maintaining resident room temperatures at a comfortable level and none provided. | F 253 | | |
| F 312 SS=D | 483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to provide assistance with grooming for 1 of 1 resident (R2) who was totally dependent on staff to meet activities of daily living (ADLs).<br><br>Findings include:<br><br>R2's quarterly Minimum Data Set, (MDS) dated 6/9/17, indicated intact cognition, and total dependence with personal hygiene and grooming. Further indicated to have diagnosis of right sided hemiplegia and left arm amputee below the shoulder and above the elbow.<br><br>R2's care plan dated 2/21/17, indicated, "Personal hygiene assistance of one/fully dependent on staff." | F 312 | Shaving was provided for R2.<br><br>Residents who are unable to carry out activities of daily living have the potential to be affected.<br><br>Education has been provided to nursing staff on providing dependent residents assistance they need to meet their activities of daily living.<br><br>DNS/designee will complete random audits of dependent residents shaving weekly x 4 weeks then monthly x 2 months. Negative findings will be addressed immediately. Results will be communicated to facility QAPI committee. | 10/24/17 |

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| F 312 | Continued From page 6<br>During observation on 9/11/17, at 6:58 p.m., R2 was sitting in his wheel chair in his room and noted to have unshaven facial hairs.<br><br>During observation on 9/12/17, at 8:33 a.m., R2 sitting in his wheelchair in the dining room for breakfast and continues to have unshaven facial hairs.<br><br>During observation on 9/13/17, at 7:28 a.m., R2 laying in his bed in his room with continued unshaven facial hairs.<br><br>During observation on 9/13/17, at 7:36 a.m., R2 was being assisted with am cares by nursing assistant (NA)-A. NA-A stated to R2, "Oh, you are getting kind of scruffy, looks like you could use a shave!" R2 stated, "Ya! Ya!"<br><br>On 9/13/17, at 8:39 a.m., R2 stated, "Last time I was shaved was Saturday ...I would at least like to be shaved every other day ...I have my own electric shaver, but I can't do it myself."<br><br>On 9/13/17, at 8:43 a.m., NA-A stated she will ask resident's everyday if they would like to be shaved. NA-A verified R2 should have been shaved today.<br><br>On 9/13/17, at 8:46 a.m. registered nurse (RN)-A stated residents should be shaved per their preference. RN-A verified R2 needs to be shaved and stated, "I noticed that when I gave him his medicine this morning."<br><br>On 9/13/17, at 8:58 a.m., director of nursing (DON) stated residents should be shaved per their preference and at least done on their bath day. DON verified R2 should have been shaved | F 312 | Completion date 10/24/17 | |

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| F 312 | Continued From page 7<br>on Tuesday, his bath day.<br><br>On 9/13/17, at 12:19 p.m., R2 stated to this surveyor with a smile on his face, "I got shaved!" and he looked freshly shaven.<br><br>Policy dated 2001, revised October, 2010, titled, "Shaving the resident," indicated the purpose of this procedure is to promote cleanliness and to provide skin care. Further indicated to document the procedure and report to the supervisor if the resident refuses the procedure. | F 312 | | |
| F 441 SS=F | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(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 (facility assessment implementation is Phase 2);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the | F 441 | | 10/24/17 |

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| F 441 | Continued From page 8 | F 441 | | |

facility;

(ii) When and to whom possible incidents of 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.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an annual review of its IPCP and update their

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| F 441 | Continued From page 9<br>program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to provide infection control education practices and procedures to all facility staff and failed to implement a program to prevent Legionella in the facility water systems to prevent an outbreak of Legionnaires disease. This had the potential to affect all of 28 residents residing in the facility, visitors, and staff.<br><br>Findings include:<br><br>During an interview on 9/14/17, at 1:37 p.m., director of nursing, (DON) stated there is not a formalized educational infection control training program at this point and the most current training they had was from 4/4/16. DON further stated new employees had not had any infection control training yet and the new employee training consists of, "being on the floor and talking through things."<br><br>An undated policy titled, "Employee training on Infection Control," indicates the facility shall provide staff with appropriate information and instruction about infection control through various means, including orientation and ongoing training programs. All staff will complete orientation and training on preventing the transmission of healthcare associated infections. Topics will include: standard precautions, transmission based precautions, OSHA blood borne pathogens, PPE use, prevention, transmission, monitoring and treatment of multi drug resistant organisms and communicable diseases, information about the uses of vaccines as an adjunct to infection control measures, sanitation | F 441 | Infection control education has been provided to all facility staff. The facility has implemented a program to prevent Legionella in the facility water systems to prevent an outbreak of Legionnaires disease.<br><br>All residents have the potential to be affected if infection control programs are not implemented and followed.<br><br>ED will audit infection control program monthly. Negative findings will be addressed immediately. Results will be communicated to facility QAPI committee.<br><br>Completion date 10/24/17 | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **LA CRESCENT HEALTH SERVICES** | **101 SOUTH HILL STREET LA CRESCENT, MN 55947** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 441 | Continued From page 10<br>procedures, and information on newly developed or revised policy and procedures. Policy further indicates the infection control officer will maintain appropriate records of topics, content, and attendance at any training sessions, as well as copies of any handouts, pre/posttests, and competency demonstrations checklists.<br><br>During an interview on 9/14/17, at 1:35 p.m., the DON was asked if the facility had developed a policy and procedure to reduce the risk, growth, spread of Legionella (Legionella bacteria are microscopic organisms that live in the soil and water and are the most common cause of Legionnaire's disease), and other opportunistic pathogens in building systems. The DON stated they did not have a policy and did not implement a facility system to monitor for Legionella bacteria. | F 441 | | |

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|---|---|---|---|
| | 245319 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **09/18/2017** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY Aspen with Deficiencies<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (LaCrescent Health Services) was found not 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES<br>( K-TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St Paul, MN 55101-5145, or | K 000 | | |

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

Electronically Signed | 10/13/2017

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<br><br>By email to:<br>Marian.Whitney@state.mn.us and<br>Angela.Kappenman@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br>The LaCrescent, is a 1-story building with no basement. The facility was constructed in 1968 and was determined to be of Type II(000) construction<br><br>The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.<br><br>The facility has a capacity of 44 beds and had a census of 28 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 341<br>SS=F | NFPA 101 Fire Alarm System - Installation<br><br>Fire Alarm System - Installation<br>A fire alarm system is installed with systems and components approved for the purpose in | K 341 | | 10/13/17 |

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| K 341 | Continued From page 2<br>accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.<br>18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8<br><br>This STANDARD is not met as evidenced by:<br>Fire Alarm System - Installation<br>A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.<br>18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8<br><br>Findings Include:<br><br>On facility tour between 09:30 AM and 01:30 PM on 9-18-2017, based on documentation review and interview that the following include:<br>Fire Alarm Contractor annual report noted that two smoke detectors needed to be replaced in | K 341 | The alarm company has inspected the malfunctioning smoke detectors and they are researching to determine if the detectors can be repaired or replaced.<br><br>All residents, staff, and visitors have the potential to be affected if the fire alarm system is not working at its full capacity.<br><br>Bids for the replacement of the fire alarm system are being sought in the event that the smoke detectors are not replaceable. A plan for replacement will be in place.<br><br>The facility will work to have the smoke detectors in working order in the next 6 months. | |

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| K 341 | Continued From page 3<br>room 202 and at the nurses station. Facility Maintenance Director stated the fire alarm system is out dated and can not be completed. They are taking bids to replace system.<br><br>This deficient practice could affect the safety of all the residents, staff and visitors within the facility.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 341 | | |
| K 374 SS=D | NFPA 101 Subdivision of Building Spaces - Smoke Barrie<br><br>Subdivision of Building Spaces - Smoke Barrier Doors<br>2012 EXISTING<br>Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.<br>19.3.7.6, 19.3.7.8, 19.3.7.9<br>This STANDARD is not met as evidenced by:<br>Subdivision of Building Spaces - Smoke Barrier Doors<br>2012 EXISTING<br>Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window | K 374 | The smoke compartment door located next to room 103 was repaired and closed properly.<br><br>All residents have the potential to be affected if the smoke compartment doors do not close when alarm is triggered. | 10/24/17 |

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| K 374 | Continued From page 4<br>assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.<br>19.3.7.6, 19.3.7.8, 19.3.7.9<br><br>Findings Include:<br><br>On facility tour between 09:30 AM and 01:30 PM on 9-18-17, based on observation and interview revealed that the following include:<br><br>Smoke compartment door located next to room 103 does not close when tested.<br><br>This deficient practice could affect the safety of all (11) the residents, staff and visitors within the smoke compartment.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 374 | Smoke barrier doors will be tested during monthly fire drills for proper closure by the maintenance staff. Results will be communicated to facility QAPI committee.<br><br>Completion date 10/24/17 | |
| K 521<br>SS=F | NFPA 101 HVAC<br><br>HVAC<br>Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.<br>18.5.2.1, 19.5.2.1, 9.2<br><br>This STANDARD is not met as evidenced by:<br>Heating, ventilation, and air conditioning shall | K 521 | Waiver submitted via email to Tom | 10/13/17 |

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| K 521 | Continued From page 5<br>comply with 9.2 and shall be installed in accordance with the manufacturer's specifications.<br>18.5.2.1, 19.5.2.1, 9.2<br><br>Findings Include:<br><br>On facility tour between 09:30 AM and 01:30 PM on 9-18-17, based on observation and interview revealed that the following include:<br><br>Observation and interview with the Facility Maintenance Director revealed that the ventilation system in the 100 and 200 wings, utilizes the egress corridor as the supply air for the resident rooms<br><br>This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartments.<br><br>This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery. | K 521 | Linhoff<br><br>A waiver is requested for K521 for the following reasons:<br><br>A)There will be no adverse effects on the health and safety of the facility's residents and staff since:<br>1. The building is equipped with an approved corridor smoke detection system.<br>2. The building has automatic shut down of ventilation fans/HVAC system upon detection of smoke or activation of the building fire alarm system.<br>3. Annual service and maintenance contracts exist to service all the facility's fire protection systems (for example; fire alarms, sprinkler system, portable extinguishers).<br>4. The building fire alarm system is monitored to provide automatic fire department notification.<br>5. Fire safety training is provided for employees on an annual basis and during orientation for new hires.<br>6. Fire drills are conducted at least quarterly on each shift.<br>7. The facility is protected by a supervised automatic sprinkler system.<br>B)Compliance with this provision would impose an unreasonable hardship on the facility since:<br>1. It would cost an estimated $246,312.00 to upgrade the HVAC system to comply with the NPPA 90A. This figure does not include upgrading the electrical system to accommodate the HVAC equipment.<br>C)This tag was previously sited and | |

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| K 521 | Continued From page 6 | K 521 | recommendations were reviewed. A waiver for this tag is requested.<br><br>Bid for replacement was emailed. | |