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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 404P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00065

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245328**
2.STATE VENDOR OR MEDICAID NO.
(L2) **427240400**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE MARGARET S PARMLYRESIDENCE**
(L4) **28210 OLD TOWNE ROAD**
(L5) **CHISAGO CITY, MN** (L6) **55013**

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 **09/16/2016** (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 **101** (L18)
13.Total Certified Beds **101** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	101			
(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 :
Amy Charais, HFE NEII 09/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/10/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245328

November 10, 2016

Ms. Julie Spiers, Administrator
The Margaret S Parmly Residence
28210 Old Towne Road
Chisago City, Minnesota 55013

Dear Ms. Spiers:

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 September 9, 2016 the above facility is certified for or recommended for:

101 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 101 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@health.state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 26, 2016

Ms. Julie Spiers, Administrator
The Margaret S Parmly Residence
28210 Old Towne Road
Chisago City, Minnesota 55013

RE: Project Number S5328024

Dear Ms.. Spiers:

On August 19, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 5, 2016. 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 September 16, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 12, 2016 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 August 5, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 9, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 5, 2016, effective September 9, 2016 and therefore remedies outlined in our letter to you dated August 19, 2016, 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 related to this letter / eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245328 Y1	A. Building B. Wing Y2	9/16/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225	Correction	ID Prefix F0226	Correction	ID Prefix F0241	Correction
Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed	Reg. # 483.15(a)	Completed
LSC	09/09/2016	LSC	09/09/2016	LSC	09/09/2016
ID Prefix F0280	Correction	ID Prefix F0323	Correction	ID Prefix F0371	Correction
Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.35(i)	Completed
LSC	09/09/2016	LSC	09/09/2016	LSC	09/09/2016
ID Prefix F0431	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(b), (d), (e)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/09/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	GL/mm	09/26/2016	35569	09/16/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/5/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245328 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/12/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0011	09/09/2016	LSC K0018	09/09/2016	LSC K0038	09/09/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0052	09/09/2016	LSC K0062	09/09/2016	LSC K0070	09/09/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0144	09/09/2016	LSC K0154	09/09/2016	LSC K0155	09/09/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	09/26/2016	27200	09/12/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/3/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245328 Y1	A. Building 02 - THE MARGARET S. PARMLEY RESIDENCE B. Wing Y2	9/12/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0038	09/09/2016	LSC K0052	09/09/2016	LSC K0062	09/09/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0070	09/09/2016	LSC K0144	09/09/2016	LSC K0154	09/09/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0155	09/09/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TL/mm	09/26/2016	27200	09/12/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/3/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 404P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00065

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245328**
2.STATE VENDOR OR MEDICAID NO.
(L2) **427240400**

3. NAME AND ADDRESS OF FACILITY
(L3) **THE MARGARET S PARMLY RESIDENCE**
(L4) **28210 OLD TOWNE ROAD**
(L5) **CHISAGO CITY, MN** (L6) **55013**

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 **08/05/2016** (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 **101** (L18)
13.Total Certified Beds **101** (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)
___ 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
	101			
(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 :
Carrie Euerle, HFE NEII 09/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/23/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 19, 2016

Ms. Julie Spiers, Administrator
The Margaret S Parmly Residence
28210 Old Towne Road
Chisago City, MN 55013

RE: Project Number S5328024

Dear Ms.. Spiers:

On August 5, 2016, 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Building
11 East Superior Street, Suite #290
Duluth, Minnesota 55802
Email: Teresa.Ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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 September 14, 2016, 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 September 14, 2016 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 November 5, 2016 (three months after

the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 5, 2017 (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, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING _____ B. WING _____	08/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. 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 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		9/9/16

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

Electronically Signed | 08/26/2016

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 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure alleged violations involving resident to resident altercation, falls and elopements were immediately reported to the state agency (SA) and/or investigative reports submitted within 5 days for 4 of 6 residents (R86, R22, R183, R106) whose incidents were reviewed. Findings include: R86 drove his electric wheelchair at a high rate of speed hitting R22. The facility failed to immediately report to the state agency. R86 had diagnoses of dementia with behavioral disturbance, Alzheimer's, polyneuropathy listed on the Admission Record dated 8/5/16. R86's quarterly Minimum Data Set (MDS) dated 5/18/16, indicated he required extensive assist of two staff members for bed mobility, toileting,	F 225	Incidents with R86, R22, R183 and R106 have all been reported to the state agency. To ensure ongoing compliance, the VA policy and procedures were reviewed, no changes were made. To ensure that all alleged violations are reported immediately to the administrator and to the appropriate state agencies, all staff received education on the vulnerable adult policy and procedure, which includes verbally speaking to a supervisor. DON and/or designee will be responsible for ongoing compliance.	

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F 225	Continued From page 2	F 225		

transfers, personal hygiene and dressing. The MDS indicated he did not ambulate and required supervision for locomotion on and off the unit with a power wheel chair. A previous MDS dated 2/18/16, indicated he was cognitively intact.

R86's current plan of care with revision date 2/19/16, identified R86 has a history of harm to others, the potential to be physically aggressive using his power wheelchair to run into staff and attempting to grab at a resident's throat.

R22 had diagnoses that included Alzheimer's and dementia without behavioral disturbance listed on the Admission Record dated 8/5/16. The quarterly MDS dated 7/5/16, indicated R22 had moderate cognitive impairment. R22's progress note dated 2/20/16, indicated R22 had no apparent injuries and stated "I am OK but I was scared" and 15 minutes later R22 told staff "I am still nervous."

An incident report dated 2/20/16, indicated R86 came through the dayroom at 8:50 p.m. at a high rate of speed on his electric wheelchair. R86 hit the first recliner without slowing down, pushing it out of the way. R86 then hit a second recliner with R22 laying in it, without stopping. The second recliner was pushed into a side table which overturned, breaking a potted plant. R86 stopped when hitting a register. R86 told staff "I couldn't stop." The report further indicated R86 had a history of running his electric scooter into inanimate objects or walls, had run into other residents, had a lack of control with driving the "scooter" at faster speeds, becomes easily angered with staff and not having his scooter set to slow speeds per his care plan as "he wanted to get somewhere fast." The plan for correction

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F 225	Continued From page 3	F 225		

included R86 to use electric scooter in room only and manual wheelchair in hallway.

Review of the incident report indicated the resident to resident altercation was never reported to the state agency.

During an interview on 8/5/16, at 11:06 a.m. Administrator stated she did not remember if the incident was reported but "if a resident felt scared and threatened then absolutely it should have been."

R86 had an unwitnessed fall from his motorized wheelchair outside and off the grounds of the facility, the facility failed to immediately report to the state agency.

An incident report dated 6/26/16, indicated the unwitnessed fall was "incident only - fall off campus and that at 6:15 p.m. CNA escorted resident (R86) to Parkside patio door for him to go outside per care plan. 6:30 p.m., R86 tipped over in his scooter on his R [right] side on the Old Town Road construction area outside of Parmly [facility], 1 block down. Bystanders helped resident tip scooter upright w [with]/him in it. 9-1-1 was called by bystanders. Paramedics called Parmly. Resident refused Paramedics offer to have him checked @ [at] the hospital. Parmly staff RN [registered nurse] escorted resident back to Parmly. Resident rode his scooter back. Paramedics took VS [vital signs] at the scene, but did not report them to our staff. ROM [range of motion] completed at scene - RN (staff) reported it was WNL [within normal limits] for resident." The report further indicated R86 had the ability to make choices about where he goes on the grounds in his electric wheelchair and is alert and

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F 225	Continued From page 4	F 225		

oriented. The plan of correction indicated staff would use a timer to check with R86 at scheduled intervals when he goes outside.

Review of the incident report indicated the unwitnessed fall was never was reported to the state agency.

R86 had an unwitnessed fall from his motorized scooter, the facility failed to immediately report to the state agency.

An incident report dated 7/2/16, indicated at 2:45 p.m. in a cul-de-sac one block from the facility "resident (R86) was driving on the street and hit the curb causing his scooter to tip on its side. Passer by heard him calling for help and called 911 and Parmly." The report further indicated R86 had a pattern of going outside with his scooter in the construction area and indicated this was his second fall outside in the construction area and second call made to 911 by an outside person. The plan of correction indicated that R86 would be attended by staff if he chose to go outside in his scooter.

Review of the incident report indicated the unwitnessed fall was never was reported to the state agency.

During an interview on 8/5/16, at 11:08 a.m. Administrator stated R86 typically goes around "the loop" and on the days of the 6/26/16 and 7/2/16 incidents, he started going off campus. When he fell we said he had to be escorted. Administrator stated staff did not know the "exact location" of R86, believed one of the times he called 911 himself and did not feel the incidents were reportable.

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F 225	Continued From page 5	F 225		

R183 eloped from the facility, the facility failed to immediately report to the state agency.

R183 was admitted on 7/12/16, and had diagnoses of traumatic brain injury with skull fracture listed on the Admission Record dated 8/4/16. The admission MDS dated 7/19/16, indicated R183 had severe cognitive impairment. A Care Area Assessment (CAA) dated 7/25/16, indicated R183 was alert and oriented to self and family, but not situation and had poor judgment and decision making abilities. An elopement assessment dated 8/1/16, the day after the incident, indicated R183 was at high risk for wandering.

An incident report dated 7/31/16, indicated at "11:35 a.m. NAR [nursing aide] approached by visitor outside, was told there was a man sitting on the bench outside Vitalize Wellness Center saying he was going to walk to Spooner." The report further indicated R183 was last checked on at 11:30 a.m. on the station and wanderguard was applied to right wrist.

Review of the incident report indicated the elopement was submitted to the state agency on 8/1/16, one day after the incident.

During an interview on 8/5/16, at 11:06 a.m. Administrator stated although she got the email regarding the incident, she was not sure what it meant and didn't call the facility. "We talked about it on Monday and called it in, the nurse should have called us." The director of nursing (DON) stated "processes are changing."

R106 suffered a hip fracture after an unwitnessed

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fall and the incident was not immediately reported nor was investigation submitted timely to the SA.

R106 had diagnoses of Alzheimer's, dementia with behavioral disturbance listed on the Admission Record dated 8/4/16. The Admission MDS dated 5/19/16, indicated R106 had moderate cognitive impairment. A Care Area Assessment (CAA) dated 2/26/16, indicated R106 had severe cognitive impairment and required extensive assist of two staff members for bed mobility and transfers.

An incident report dated 12/19/15, indicated at 2:30 p.m. R106 was noted to have an unwitnessed fall resulting in a hip fracture. A nursing assistant heard a scream for help and found R106 on the floor in the dayroom/dining room on her back holding her legs in the air. R106 was sent to the hospital and required pinning of the right hip.

Review of the incident report indicated the report was not submitted to the SA until 12/21/15, two days after the incident occurred. In addition the investigation was submitted on 12/29/15, seven working days after the incident occurred.

During an interview on 8/4/16, at 11:24 a.m. the administrator stated she did not know why it was reported two days later and verified the submission of the investigation was late.

During an interview on 8/4/16, at 11:55 a.m. the administrator stated staff should have called the SA. The administrator would "absolutely expect that any falls with fractures would be reported."

The Ecumen Abuse Prevention Plan for

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F 225	Continued From page 7 Minnesota SNFs [skilled nursing facilities] Policy & Procedure with a revision date of 7/15, indicated mandated reporters who have reason to believe that a vulnerable adult is being or has been maltreated/mistreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, shall immediately report the information to the DON or designee. The facility professional who receives the report of suspected maltreatment/mistreatment is then responsible for immediately reporting to the Administrator or designee, the Minnesota Department of Health and the CEP. The policy further indicated internal investigation results must be reported to the MDH [Minnesota Department of Health] and facility Administrator or Administrator's designee within 5 working days of the initial report.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement the abuse prevention policy for notifying the State Agency (SA) immediately and providing reports of investigations within 5 working days regarding resident to resident altercation, falls and elopements for 4 of 6 residents (R86, R22, R183, R106) whose incidents were reviewed.	F 226	Incidents with R86, R22, R183 and R106 have all been reported to the state agency. To ensure ongoing compliance, the VA policy and procedures were reviewed, no changes were made. To ensure that all alleged violations are reported immediately to the administrator and to the appropriate state agencies, all	9/9/16

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F 226	Continued From page 8 Findings include: The Ecumen Abuse Prevention Plan for Minnesota SNFs [skilled nursing facilities] Policy & Procedure with a revision date of 7/15, indicated mandated reporters who have reason to believe that a vulnerable adult is being or has been maltreated/mistreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained, shall immediately report the information to the DON or designee. The facility professional who receives the report of suspected maltreatment/mistreatment is then responsible for immediately reporting to the Administrator or designee, the Minnesota Department of Health and the CEP. The policy further indicated internal investigation results must be reported to the MDH [Minnesota Department of Health] and facility Administrator or Administrator's designee within 5 working days of the initial report. R86 drove his electric wheelchair at a high rate of speed hitting R22. The facility failed to immediately report to the state agency according to facility policy. R86 had diagnoses of dementia with behavioral disturbance, Alzheimer's, polyneuropathy listed on the Admission Record dated 8/5/16. R86's quarterly Minimum Data Set (MDS) dated 5/18/16, indicated he required extensive assist of two staff members for bed mobility, toileting, transfers, personal hygiene and dressing. The MDS indicated he did not ambulate and required supervision for locomotion on and off the unit with a power wheel chair. A previous MDS dated 2/18/16, indicated he was cognitively intact.	F 226	staff received education on the vulnerable adult policy and procedure, which includes verbally speaking to a supervisor. DON and/or designee will be responsible for ongoing compliance.	

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R86's current plan of care with revision date 2/19/16, identified R86 has a history of harm to others, the potential to be physically aggressive using his power wheelchair to run into staff and attempting to grab at a resident's throat.

R22 had diagnoses that included Alzheimer's and dementia without behavioral disturbance listed on the Admission Record dated 8/5/16. The quarterly MDS dated 7/5/16, indicated R22 had moderate cognitive impairment. R22's progress note dated 2/20/16, indicated R22 had no apparent injuries and stated "I am OK but I was scared" and 15 minutes later R22 told staff "I am still nervous."

An incident report dated 2/20/16, indicated R86 came through the dayroom at 8:50 p.m. at a high rate of speed on his electric wheelchair. R86 hit the first recliner without slowing down, pushing it out of the way. R86 then hit a second recliner with R22 laying in it, without stopping. The second recliner was pushed into a side table which overturned, breaking a potted plant. R86 stopped when hitting a register. R86 told staff "I couldn't stop." The report further indicated R86 had a history of running his electric scooter into inanimate objects or walls, had run into other residents, had a lack of control with driving the "scooter" at faster speeds, becomes easily angered with staff and not having his scooter set to slow speeds per his care plan as "he wanted to get somewhere fast." The plan for correction included R86 to use electric scooter in room only and manual wheelchair in hallway.

Review of the incident report indicated the resident to resident altercation was never

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F 226	Continued From page 10 reported to the state agency. During an interview on 8/5/16, at 11:06 a.m. Administrator stated she did not remember if the incident was reported but "if a resident felt scared and threatened then absolutely it should have been." Although the facility was aware of the resident to resident altercation between R86 and R22, the incident was never was reported to the state agency according to facility policy. R86 had an unwitnessed fall from his motorized wheelchair outside and off the grounds of the facility, the facility failed to immediately report to the state agency according to facility policy. An incident report dated 6/26/16, indicated the unwitnessed fall was "incident only - fall off campus and that at 6:15 p.m. CNA escorted resident (R86) to Parkside patio door for him to go outside per care plan. 6:30 p.m., R86 tipped over in his scooter on his R [right] side on the Old Town Road construction area outside of Parmly [facility], 1 block down. Bystanders helped resident tip scooter upright w [with]/him in it. 9-1-1 was called by bystanders. Paramedics called Parmly. Resident refused Paramedics offer to have him checked @ [at] the hospital. Parmly staff RN [registered nurse] escorted resident back to Parmly. Resident rode his scooter back. Paramedics took VS [vital signs] at the scene, but did not report them to our staff. ROM [range of motion] completed at scene - RN (staff) reported it was WNL [within normal limits] for resident." The report further indicated R86 had the ability to make choices about where he goes on the grounds in his electric wheelchair and is alert and	F 226		

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oriented. The plan of correction indicated staff would use a timer to check with R86 at scheduled intervals when he goes outside.

Review of the incident report indicated the unwitnessed fall was never was reported to the state agency.

R86 had an unwitnessed fall from his motorized scooter, the facility failed to immediately report to the state agency.

An incident report dated 7/2/16, indicated at 2:45 p.m. in a cul-de-sac one block from the facility "resident (R86) was driving on the street and hit the curb causing his scooter to tip on its side. Passer by heard him calling for help and called 911 and Parmly." The report further indicated R86 had a pattern of going outside with his scooter in the construction area and indicated this was his second fall outside in the construction area and second call made to 911 by an outside person. The plan of correction indicated that R86 would be attended by staff if he chose to go outside in his scooter.

Review of the incident report indicated the unwitnessed fall was never was reported to the state agency.

During an interview on 8/5/16, at 11:08 a.m. Administrator stated R86 typically goes around "the loop" and on the days of the 6/26/16 and 7/2/16 incidents, he started going off campus. When he fell we said he had to be escorted. Administrator stated staff did not know the "exact location" of R86, believed one of the times he called 911 himself and did not feel the incidents were reportable.

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THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 12	F 226		

R183 eloped from the facility, the facility failed to immediately report to the state agency as directed by facility policy.

R183 was admitted on 7/12/16, and had diagnoses of traumatic brain injury with skull fracture listed on the Admission Record dated 8/4/16. The admission MDS dated 7/19/16, indicated R183 had severe cognitive impairment. A Care Area Assessment (CAA) dated 7/25/16, indicated R183 was alert and oriented to self and family, but not situation and had poor judgment and decision making abilities. An elopement assessment dated 8/1/16, the day after the incident, indicated R183 was at high risk for wandering.

An incident report dated 7/31/16, indicated at "11:35 a.m. NAR [nursing aide] approached by visitor outside, was told there was a man sitting on the bench outside Vitalize Wellness Center saying he was going to walk to Spooner." The report further indicated R183 was last checked on at 11:30 a.m. on the station and wanderguard was applied to right wrist.

Review of the incident report indicated the elopement was submitted to the state agency on 8/1/16, one day after the incident.

During an interview on 8/5/16, at 11:06 a.m. Administrator stated although she got the email regarding the incident, she was not sure what it meant and didn't call the facility. "We talked about it on Monday and called it in, the nurse should have called us." The director of nursing (DON) stated "processes are changing."

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F 226	Continued From page 13 Although the facility was aware of the elopement, they did not notify the SA immediately as directed by facility policy. R106 suffered a hip fracture after an unwitnessed fall and the incident was not immediately reported nor investigative reported submitted timely to the SA as directed by the facility policy. R106 had diagnoses of Alzheimer's, dementia with behavioral disturbance listed on the Admission Record dated 8/4/16. The Admission MDS dated 5/19/16, indicated R106 had moderate cognitive impairment. A Care Area Assessment (CAA) dated 2/26/16, indicated R106 had severe cognitive impairment and required extensive assist of two staff members for bed mobility and transfers. An incident report dated 12/19/15, indicated at 2:30 p.m. R106 was noted to have an unwitnessed fall resulting in a hip fracture. A nursing assistant heard a scream for help and found R106 on the floor in the dayroom/dining room on her back holding her legs in the air. R106 was sent to the hospital and required pinning of the right hip. Review of the incident report indicated the report was not submitted to the SA until 12/21/15, two days after the incident occurred. In addition the investigation was submitted on 12/29/15, seven working days after the incident occurred. During an interview on 8/4/16, at 11:24 a.m. the administrator stated she did not know why it was reported two days later and verified the submission of the investigation was late.	F 226		

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F 226	Continued From page 14 During an interview on 8/4/16, at 11:55 a.m. the administrator stated staff should have called the SA. The administrator would "absolutely expect that any falls with fractures would be reported." Although R106, who had cognitive impairment, experienced a significant injury (hip fracture) from an unwitnessed fall, the facility did not notify the SA immediately, nor submit the investigative reported in a timely manner as directed by facility policy.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide toileting assistance for 1 of 1 residents (R144) reviewed for dignity. Findings include: R144 had a diagnosis of Alzheimer's Disease, was severely cognitively impaired and resided on the memory care unit of the facility. A minimum data set (MDS) care area assessment (CAA) dated 1/11/16, indicated the "resident was noted to be frequently incontinent of bladder during the assessment period. Wears incontinent product at all times. The resident has	F 241	Facility ensures to promote care for residents in a manner and in an environment that maintains or enhances each resident□s dignity. R 144's care plan and group sheets were reviewed, and no changes were made. Education was provided to staff on dignity and to follow the care plan/group sheets. Audits will be completed on all units weekly x 8 for 2 months to ensure residents receive dignity during toileting cares and that they are following the group sheets. Audits will be reviewed at the next Quality Assurance Performance Improvement meeting to determine discontinuation of audits.	9/9/16

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F 241	Continued From page 15 cognitive impairment which may be a contributing factor to incontinence. Staff are to follow the toileting program per plan of care and provide peri cares after each incontinent episode." An undated nursing assistant group sheet directed staff to "assure that his [R144] brief is dry at all times, document peri care refusals, easily redirectable. Toileting program: toilet at hs (hour of sleep) to promote bowels. He will also toilet self at times staff to attmept to go with res (resident) to bathroom for supervision and product check, if res allows put boxers over brief". R144's careplan dated 2/16/16, indicated R144 had an "ADL self-care performance deficit r/t (related to) Dx (diagnosis) of Alzheimer's Disease. Requires cueing for completion of many ADLs and frequently refuses cares. Staff to re-approach at a later time if refusal of cares. Cognitive impairment limits resident ability to perform ADLs without assistance". R144's careplan further identified R144 "requires extensive assist of 1 staff for toileting. resident is frequently incontinent of bowel and bladder and requires assist with peri cares and product changes. Resident will frequently refuse cares of staff. Staff to re-approach if refusal". On 8/1/16, at 5:10 p.m. LPN-B assisted R144 out of a recliner chair in the dining/living room area. R144 was wearing gray sweatpants and a large wet area was observed on the back of his pants. LPN-B directed NA-E to assist R144. NA-E placed a transfer belt around R144's waist and walked R144 to a dining room chair across the room and assisted him to sit in the chair. NA-E did not offer or assist R144 to the toilet prior to assisting him to the chair for the evening meal.	F 241	DON and/or designee responsible for ongoing compliance.	

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R144 remained seated in the chair during the evening meal. At 5:40 p.m. R144 stood up from the table and walked toward the doors of another unit. NA-G followed R144 off the unit and redirected R144 back to the unit. At 5:45 p.m. LPN-B asked NA-F to assist her with placing a recliner chair downstairs because it was soiled. It was the chair R144 had been seated in prior to the meal.

LPN-B was interviewed on 8/1/16, at 5:45 p.m. and stated she had told staff the recliner was soiled and asked staff to assist R144 to the toilet. LPN-B then asked NA-G if she had toileted R144 prior to the evening meal. NA-G stated they all asked him and he refused assistance with toileting.

On 8/1/16, at 5:49 p.m. R144 was observed to refuse assistance from NA-G to use the bathroom. At 5:53 p.m. NA-E assisted R144 to the bathroom located near the dining room area. At 5:57 p.m. NA-E and R144 exited the bathroom. R144's pants were again observed to have a large wet area on the back.

NA-E was interviewed on 8/1/16, at 5:57 p.m. and stated she asked R144 to use the bathroom prior to assisting him to his dining room chair. NA-E stated she wrote this down on the toileting sheet and that R144 often refused toileting. NA-E obtained the toileting sheet and stated "Oh, I must not have written this down." There was no documentation for the 5:00 p.m. hour on R144's toileting plan. NA-E stated that NA-F also attempted to toilet R144 but he had again refused. NA-E was asked if she changed R144's pants when she assisted him to the bathroom. NA-E stated "What? They were wet? I didn't see

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F 241	Continued From page 17 that." NA-E confirmed she had not assisted R144 to change his pants when she assisted him to the bathroom. On 8/1/16, at 6:01 p.m. NA-E directed R144 to his room. R144 returned to the dining room later wearing a clean pair of pants. The Director of Nursing (DON) was interviewed on 8/5/16, at 9:59 a.m. and indicated she expected staff to toilet residents in accordance with their plan of care. She expected staff would change the soiled pants of residents at the time they were assisted with toileting. A policy entitled Quality of Life-Dignity dated 2009 indicated "Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality". The policy further indicated "residents shall be treated with dignity and respect at all times" and "treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteen and self-worth" and further indicated "demeaning practices and standards of care that compromise dignity are prohibited".	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280		9/9/16

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F 280	Continued From page 18 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, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to re-assess the effectiveness of safety interventions of 1 of 1 residents (R86) reviewed for accidents and supervision, who was assessed to be unsafe to operate a motorized wheel chair. Findings include: R86's quarterly minimum data set (MDS) dated 5/18/16, indicated he did not ambulate and required supervision for locomotion on and off the unit with a power wheel chair. A previous MDS dated 2/18/16, indicated he was cognitively intact. R86's care plan dated 5/26/16, identified impaired mobility and weakness and a history of attempting to perform daily cares independently and unsafely. The care plan further identified behaviors that included "purposefully using electric WC [wheel chair] to run into walls, facility, staff when angered." As well as the potential to be physically aggressive using his power wheel chair to run into staff and a history of harm to	F 280	Resident # 86 was reassessed per Occupational safety for operating a motorized wheel chair and recommendations were that he was not safe to operate. Resident # 86 at present is using a manual wheel chair. R86's care plan was reviewed and updated. The Electronic Motorized Device Policy and Procedure was reviewed and revised. Education was provided to nursing and therapy to assess effectiveness of safety before a resident operates a motorized chair. All current residents with electronic motorized devices were reassessed for safety per protocol. Any new resident with an electronic motorized device will be assessed by nursing and therapy per protocol. Any concerns will be reviewed by IDT per policy. DON and/or designee will be responsible for ongoing compliance.	

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F 280	Continued From page 19 others. During an observation on 8/1/16, at 2:28 p.m., R86 was sitting in a recliner chair in his room. was holding a remote in his right had. His hand was visibly shaking. During a subsequent observation at 6:59 p.m., R86 continued to recline in his chair with his arms and hand shaking. A review of Margaret S Parmly Residence Progress notes dated 11/1/15 through 8/5/16 identified multiple examples of R86 running into equipment, furniture and walls, into and over people and near misses when using the electric scooter. In addition the notes identified several occasions when R86 refused to be compliant with restrictions placed on the use of the motorized wheelchair and intentionally running into things when angered/frustrated. Staff noted R86 to have a "slow response time" contributing to the incidents and staff needed to move other residents out of the way to "ensure their safety." R86 was also identified to have 2 incidents in which he took his motorized wheelchair into a road construction area and overturned the chair. Emergency Medical Services (EMS 911) was activated by bystanders on both occasions. A review of an Occupation Therapy (OT) Discharge Summary dated 12/8/16, indicated R86 had completed assessments demonstrating concerns with safety on problem solving changes in the environment. The discharge summary further indicated OT provided nursing with a manual wheel chair, which they are not planning to issue. A previous OT assessment dated 5/26/15 indicated caregivers reported concerns with safety re: use of power wheel chair. Due to	F 280		

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the incidents that have happened, along with reports from staff, it was recommended that R86's power chair be removed and he use a manual wheel chair.

On 8/4/16, at 11:13 a.m., occupational therapist (OT)-G stated they have recommended R86's power wheel chair be pulled several times.

On 8/4/16, at 3:11 p.m., nursing assistant (NA)-H stated R86 has had falls in his scooter because he has gone "off roading." NA-H stated staff keep and eye on him when he goes outside. NA-H stated R86 has not run into any people recently but he takes the corners too fast in his chair and "takes out furniture."

On 8/4/16, at 3:20 p.m., NA-D stated she knew R86 well. She stated when he goes outside, staff check on him every 5 minutes. She stated R86 knows not to go down to the construction anymore.

On 8/5/16, at 10:56 a.m., registered nurse (RN)-A stated the facility implemented staff escorting R86 outside.

On 8/5/16, at 9:55 a.m., social worker (SW)-B stated R86 was only allowed to use his power chair in his room unattended. She stated if he left his room, staff would walk with him if he would allow it. If not, staff would follow him at a distance.

On 8/5/16, at 10:34 a.m., NA-A stated staff have to escort R86 outside and then they can leave him out there.

On 8/5/16, at 11:08 a.m., The facility

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F 280	Continued From page 21 administrator stated when R86 went outside and fell out of his scooter the facility put restrictions on his use of it. The adminstrator stated R86's safety awareness and judgement is difficult to assess and stated he has and "old time" mentality. She stated since the new interventions had been implemented R86 had not been reassessed to determine if he is safe to use the power chair. While R86 had been assessed to be unsafe to operate his motorized wheel chair and multiple incidents had occurred as a result, R86 continued to use his power chair in the facility. Further, interventions for safety had been identified for implementation, however there was no indication the facility had re-assessed the efficacy of the interventions. A facility policy titled Ecumen Assessment - IDT, dated 4/08, indicated assessments are reviewed and updated as needed, e.g. hospitalization, acute illness, change in status. The policy further indicated professional staff must use their judgement and complete other assessments, as needed.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323		9/9/16

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F 323	Continued From page 22 by: Based on observation, interview and document review, the facility failed to implement interventions to prevent accidents for 1 of 1 residents (R86) assessed to be unsafe operating an electric wheel chair. Findings include: R86's quarterly Minimum Data Set (MDS) dated 5/18/16, indicated he required extensive assist of two staff members for bed mobility, toileting, transfers, personal hygiene and dressing. The MDS indicated he did not ambulate and required supervision for locomotion on and off the unit with a power wheel chair. A previous MDS dated 2/18/16, indicated he was cognitively intact. A review of a Margaret S Parmly Residence Diagnosis Report identified diagnosis that included: Vascular Dementia with Behavioral Disturbance and Alzheimer's disease. R86's care plan dated 5/26/16, identified a self-care deficit related to limited mobility and weakness and a history of attempting to perform daily cares independently and unsafely. The care plan further identified behaviors that included "purposefully using electric WC [wheel chair] to run into walls, facility, and staff when angered." As well as the potential to be physically aggressive using his power wheel chair to run into staff and a history of harm to others. A review of Margaret S Parmly Residence Progress notes dated 11/1/15 through 8/5/16, indicated the following: - 11/15/15, staff were called to R86's room to	F 323	Resident # 86 was reassessed per Occupational safety for operating a motorized wheel chair and recommendations were that he was not safe to operate. Resident # 86 at present is using a manual wheel chair. R86's care plan was reviewed and updated. The Electronic Motorized Device Policy and Procedure was reviewed and revised. Education was provided to nursing and therapy to assess effectiveness of safety before a resident operates a motorized chair. All current residents with electronic motorized devices were reassessed for safety per protocol. Any new resident with an electronic motorized device will be assessed by nursing and therapy per protocol. Any concerns will be reviewed by IDT per policy. DON and/or designee will be responsible for ongoing compliance.	

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clean up after he moved everything around with his scooter. The room had a television laying in front of his dresser, glasses were on the floor smashed, table a chair pushed against the window and his Christmas tree was on the floor.

- 12/1/15, R86 ran into another resident in the day room with his electric scooter. "Resident did not appear to realize that had hit the other resident's wheel chair." R86 was educated about scooter safety. Earlier in the day R86 ran into a wall in the day room and scraped the wall. When staff asked R86 to stop his scooter he stated "I'll stop when I want to stop."

- 12/16/15, Writer was walking down the hall and heard a "Bang." R86 was on in his electric wheel chair partially in another resident ' s room. A Bin had been knocked over with a drawer broken.

- 1/30/16, R86 had his "booze" and was on the North station leaning in his wheel chair, nursing caught him before he fell. Nursing stated he was acting "drunk."

- 2/20/16, R86 came through the day room at a high rate of speed on his electric wheelchair. He hit the two recliners in the day room, one that had a resident laying in it. R86 pushed the recliner into a side table and knocked the table over with a potted plant on it. He also ran into a heat register. R86 told staff he was unable to stop.

- 2/20/16, Follow up note regarding prior incident- R86 stated he had the speed turned up because he was in a hurry and could not stop. Staff reported he had also hit the wall in the tub room. R86 is aware that he needs to stop, "suspect that slow response time is contributing."

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24 - 2/22/16, Interdisciplinary team (IDT) discussion related to multiple incidents in electric wheel chair that caused damage to the facility and caused another resident to feel "afraid and nervous." Team feels R86 should only use his electric scooter while in his room. - 2/22/16, behavior note- R86 has behaviors that include yelling and screaming at staff, swearing at staff and using his scooter to block staff. - 2/22/16, Staff reported that R86 crashed into his night table twice in his electric wheel chair and his chair once. - 2/23/16, Director of nursing (DON) approached R86 regarding the multiple incidents in his electric wheel chair. After discussion with IDT staff feel R86 has functionally and cognitively declined and unable to safely operate his electric scooter. - 2/24/16, R86 has been angry and yelling at staff. He was observed in his electric wheel chair three times out in the hall by the kitchen area. Staff reminders that he cannot be in the hallway in his power chair. - 2/24/16, At 7:30 p.m., R86 lost control of his power wheel chair in his room and displaced his recliner and table. Later he was observed in the hallway in his chair and got stuck on the railing. The front of his wheel chair was about a foot in the air. - 2/24/16, R86 again observed outside his room in his power wheel chair. R86 stated to staff that he needed to hold on to the railing in the hallway to keep from leaning over.	F 323		

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F 323	Continued From page 25 - 2/25/16, R86 was observed out in the hallway twice in his power chair. Staff reminded him to stay in his room with his power chair and he replied that he could do whatever he wanted. - 3/3/16, R86 took his electric chair out into the hallway. Staff reminded him he could use it only in his room. When he returned to his room, R86 hit his dresser with his chair. - 3/4/16, R86 ran over a staff member's foot with his power wheel chair. - 3/7/16, R86 came out of his room in his power wheel chair. He also hit the heat register and caused a 4 foot scratch and a dent. - 3/21/16, R86 left his room in his power chair and hit the wall "hard." - 3/22/16, R86 was out of his room on his electric chair several times. One time he was observed by staff "charging" out of his room so quickly he hit the wall across the hall and "nearly hit another resident and visitor." - 4/14/16, R86 was observed out of his room in his electric wheel chair four times. - 4/16/16, R86 was outside his room in his power chair on five different occasions this evening. On one of the occasions he lost control of his scooter and drove into a mechanical lift and got his chair stuck under the machine. Another note on the same date indicated he was out of his room four more times. On the way back to his room R86 lost control of his scooter and ran into the wall.	F 323		

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- 4/17/16, R86 came out of his room in his power chair and requested to go outside. Staff told him he needed to be in a standard wheel chair. R86 continued to ride on his scooter and was headed outside. Staff had to move other residents out of the way to "ensure their safety."

- 4/22/16, R86 was observed outside his room in his power chair. Shortly after, it was reported that he lost control of his scooter and hit his reclining chair moving it a couple of feet across the room and then slammed into his closet door while on the scooter.

- 5/10/16, IDT team discussion regarding R86's power chair. IDT team feels it is appropriate at this time to have staff escort R86 to destinations outside of his room in his power chair. This is in an effort to prevent injury to himself and others from scooter collisions.

- 6/9/16, R86 has not been cooperative with his power chair. Staff reported that after supper R86 left the building to go outside in his scooter without staff assistance or knowledge.

-6/26/16, Staff received a phone call from paramedics regarding R86. R86 was in his power chair on the road, one block north of the facility. Staff had escorted him to the patio door for him to go outside. At 6:30 p.m., a bystander called the police due to R86 having tipped over in his power chair in a construction area.

- 6/27/16, Staff met with R86 regarding incident from the previous day. R86 reported that it was hard for him to see. Staff requested R86 notify staff when he plans to be outdoors and a nurse will set a timer. If R86 has not returned when the

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F 323	Continued From page 27 timer goes off, staff will "attempt to locate him and assist as appropriate." - 7/2/16, Staff escorted R86 outside on his electric wheel chair. Less than 15 minutes later a man came to the door and stated R86 was down the street and had tipped over his chair. R86 had called 911 for assistance. He was found with his head lying on the pavement but denied injury except to his right shoulder. - 7/6/16, Staff met with R86 and told him staff would be accompanying him outdoors for safety. A review of an Occupation Therapy (OT) Discharge Summary dated 12/8/16, indicated R86 was positioned for a manual wheel chair and indicated R86 had completed assessments demonstrating concerns with safety on problem solving changes in the environment. R86 has been observed by staff and family running into doorways. Patient also hit another patient. The discharge summary further indicated OT provided nursing with a manual wheel chair, which they are not planning to issue. They are waiting for a nurse practitioner. However, there was no evidence the nurse practitioner addressed R86's wheel chair. A previous OT assessment dated 5/26/15, indicated caregivers reported concerns with safety re: use of power wheel chair. Due to the incidents that have happened, along with reports from staff, it is recommended that R86's power chair be removed and he use a manual wheel chair. A facility document titled Electric Motorized Device Written/Verbal Quiz dated 8/15/15, indicated the following responses to the question, " Before backing up or out of a space, what are	F 323		

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some precautions you should take? " R86 responded, "Hope nobody is back there."

On 8/1/16, at 2:28 p.m., R86 was sitting in a recliner chair in his room. He was holding a remote in his right had. His hand was visibly shaking. During a subsequent observation at 6:59 p.m., R86 continued to recline in his chair with his arms and hand shaking.

On 8/4/16, at 11:13 a.m., occupational therapist (OT)-G stated they have recommended R86's power wheel chair be pulled several times. She stated he runs into staff and other resident's and had an incident with the construction.

On 8/4/16, at 3:11 p.m., nursing assistant (NA)-H stated R86 enjoyed going outside. She stated he has had falls in his scooter because he has gone "off roading." NA- H stated staff kept an eye on him when he goes outside. She stated if they have time they take him for a walk, but if not they will check on him when he's outside. She stated the previous day he was outside by himself twice on her shift. NA-H stated R86 has not run into any people recently but he takes the corners too fast in his chair and "takes out furniture."

On 8/4/16, at 3:16 p.m., health information coordinator (HIC)-H stated she was unsure if R86 was OK to be outside by himself or not and further stated, "he is going to do whatever he wants, however he wants, and wherever he wants."

On 8/4/16, at 3:20 p.m., NA-D stated she knew R86 well. She stated when he went outside, staff checked on him every five minutes. She stated R86 knows not to go down to the construction

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anymore.

On 8/5/16, at 10:56 a.m., registered nurse (RN)-A stated the facility implemented staff escorting R86 outside. She stated she posted a sign for staff so they would know and stated she verbally told staff they needed to accompany him. RN-A further stated staff have asked if they could leave R86 outside unattended and do 5 minute safety checks and were told they had to remain outside with him at all times.

On 8/5/16, at 9:55 a.m., social worker (SW)-B stated R86 was only allowed to use his power chair in his room unattended. She stated if he left his room, staff would walk with him if he would allow it. If not, staff would follow him at a distance.

On 8/5/16, at 10:34 a.m., NA-A stated staff had to escort R86 outside and then they could leave him out there. She stated, "We peek at him every ten minutes or so." NA-A further stated there had been a few times he got away.

On 8/5/16, at 11:08 a.m., the facility administrator stated when R86 went outside and fell out of his scooter the facility put restrictions on his use of it. She stated when he went outside and fell the facility implemented safety checks and after the second time he fell outside they implemented escorts by staff. The administrator stated R86's safety awareness and judgement is difficult to assess and stated he has an "old time" mentality. She stated since the new interventions had been implemented, R86 had not been reassessed to determine if he is safe to use the power chair. She further stated staff should have been educated regarding the new interventions but

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F 323	Continued From page 30 there was not currently a system in place to ensure the interventions were being followed. R86 had multiple incidents related to the unsafe use of his power chair and assessments indicated a lack of safety awareness and physical ability to safely operate his chair. However, R86 continued to use his power chair in the facility. Further, while the facility implemented interventions in a effort to keep R86 and other residents and staff safe, R86 continued to display non-compliance with his restrictions. There was no evidence the facility re-assessed R86's ability and willingness to comply with the restrictions. There was no evidence the staff had been educated regarding the interventions implemented to keep R86 and other residents safe in the facility. A facility policy titled Ecumen Safety Program, dated 5/07, indicated the facility promotes a culture of safety awareness with systems in place for acting on safety concerns. The facility's safety program preserves a residents right to autonomy and choice, while providing education on possible outcomes of choices made in relation to safety issues.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		9/9/16

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F 371	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor and maintain safe temperatures in the walk in refrigerator to prevent the potential spread of food borne illness and promote food safety. This had the potential to affect all 88 residents residing in the facility who received food/fluids out of the kitchen. Findings include: During the initial kitchen tour on 8/1/16, at approximately 12:00 p.m. the walk-in refrigerator was 48 degrees Fahrenheit (F). The temperature was confirmed by the certified dietary manager (CDM). Cook (C)-A was observed to take the temperatures of the food for the evening meal on 8/1/16, at 5:17 p.m. Ham sandwiches (served on a buttered bun) and corn beef sandwiches served with Thousand Island dressing were 50.7 degrees. At 5:19 p.m. the pureed ham made with mayonnaise was 58.8 degrees F. The temperatures were taken and confirmed by C-A. Although the corn beef sandwiches were served to residents, they were pulled back prior to any resident eating them. The pureed ham was not served to residents. On 8/1/16, at 5:26 p.m. the walk-in cooler was 48 degrees F. This was confirmed by the assistant dietary manager (ADM). On 8/1/16, at 6:32 p.m. dietary aide (DA)-A	F 371	Policies and procedure for Food Safety Program was reviewed, no changes were made. All kitchen and dinning staff were trained on Holding Hot and Cold Food. Training included reporting procedures when temperatures were out of acceptable ranges. Kitchen management will check refrigerator logs daily and initial log for acknowledgement. Daily temperature audits x60 days, then ongoing weekly audits. Audits will be reviewed by QAPI Committee. Kitchen and Dining Manager and/or designee responsible for ongoing compliance.	

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F 371	Continued From page 32 served the evening meal on the memory care unit (Martha's Unit) and confirmed the temperature of the sandwiches were 67 degrees F. The CDM was present during this interview. The ham sandwiches were served to 12 residents. DA-A indicated he did not take the temperature of the pureed ham as it was usually done when the food arrived on the unit. DA-A confirmed the CDM had instructed them to take food temperatures immediately upon the food arriving to the unit so any corrective action can be taken if the food was not at the proper temperature. On 8/1/16, at 7:18 p.m. the "HACCP [Hazard Analysis and Critical Control Points] Refrigerator Temperature Log" forms for the Parmly kitchen walk-in cooler were reviewed with the CDM. The directions on the temperature log sheet outlined temperatures should be taken daily with the following additional guidance: "Maintain refrigerator temperature at 40 degrees F (4 degrees C) or below during stable times." "Complete corrective action column if temperatures are not in proper ranges." "Check either an accurate internal probe (hanging or standing refrigerator thermometer) OR a built-in equipment thermometer." Upon review, the logs identified refrigerator temperatures for 5/16, and 6/16, were within acceptable range. The temperature log for 7/16, revealed the following: 7/1/16, at 1:00 p.m. temperature was recorded at 48 degrees F 7/2/16, no temperature was recorded for the day 7/3/16, at 1:00 temperature was recorded at 45 degrees F	F 371		

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F 371	Continued From page 33 7/4/16, at 1:20 temperature was recorded at 46 degrees F 7/5/16, at 1:00 temperature was recorded at 46 degrees F 7/6/16, at 1:00 temperature was recorded at 48 degrees F 7/716, at 1:00 temperature was recorded at 50 degrees F 7/8/16, no temperature was recorded for the day 7/9/16, at 5:05 temperature was recorded at 48 degrees F 7/10/16, at 6:00 temperature was recorded at 46 degrees F 7/11/16, no temperature was recorded for the day 7/12/16, at 1:00 temperature was recorded at 48 degrees F 7/13/16, at 5:00 temperature was recorded at 46 degrees F 7/14/16, at 5:20 temperature was recorded at 43 degrees F 7/15/16, 1:20 temperature was recorded at 46 degrees F 7/16/16, no temperature was recorded for the day 7/17/16, 11:45 temperature was recorded at 36 degrees F 7/18/16, 5:10 temperature was recorded at 46 degrees F 7/19/16, at 7:00 temperature was recorded at 46 degrees F 7/20/16, at 6:00 temperature was recorded at 46 degrees F 7/21/16, at 5:30 temperature was recorded at 46 degrees F 7/22/16, no temperature was recorded for the day 7/23/16, at 7:00 temperature was recorded at 46 degrees F 7/24/16, at 1:00 temperature was recorded at 46 degrees F 7/25/16, at 1:30 temperature was recorded at 49	F 371		

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degrees F
7/26/16, at 5:50 temperature was recorded at 48 degrees F
7/27/16, at 5:30 temperature was recorded at 46 degrees F
7/28/16, at 5:00 temperature was recorded at 48 degrees F
7/29/16, at 5:00 temperature was recorded at 48 degrees F
7/30/16, no temperature was recorded for the day
7/31/16, at 1:30 temperature was recorded at 42 degrees F

The CDM confirmed the log was missing temperatures for 6 of the 25 days in July, on 24 out of the 25 days, the temperatures were above 40 degrees F and the column for "Corrective Action/Comments" was blank for all 31 days. The CDM stated she was not aware of the temperature deviations for the walk-in refrigerator. "I have looked at the sheets to see if they were completed but I did not notice the temperatures. This is my responsibility and I should have known." The ADM indicated he had no knowlege of the temperature readings of the walk-in cooler.

On 8/1/16, at 7:35 p.m. the facility infection control logs were reviewed and did not reveal any food borne related resident illness for 5/16, 6/16, or 7/16.

On 8/1/16, at 7:45 p.m. the CDM and ADM initiated an inventory of the walk-in cooler. Temperature readings were taken on all food items at that time. The CDM instructed dietary staff to throw away all foods that were not within proper temperature range. All "left overs" were to be discarded. The foods that were within the

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F 371	Continued From page 35 proper temperature range were transferred to a refrigerator in the adjoining assisted living kitchen. On 8/1/16, at 8:24 p.m., the ADM continued to take temperatures of the foods in the walk-in refrigerator. The condenser in the walk-in cooler had a large amount of ice buildup. The ADM stated they have to thaw it out but was unsure of the frequency. The floor had standing water and the ADM pointed to a pan used to "catch" water from the condenser. On 8/2/16, at 5:05 a.m. C-B stated the walk-in cooler had a temperature of 48 degrees F upon his arrival at 5:00 a.m. and it was empty. Upon entering the walk-in refrigerator, C-B verified the temperature was 48 degrees F. The condenser was on and the entire floor was covered with approximately 1/4 inch of water. There was no ice observed on the condenser. C-B stated the refrigerator temperatures had been recorded by him 21 times in the month of 7/16. Additionally, C-B stated ideally the temperature should be taken in the morning but it is taken at different times throughout the day. When asked what steps were taken when the refrigerator temperature was out-of-range, C-B stated he would recheck in 20 minutes as there is a lot of activity in and out of the walk-in cooler. C-B added he did not document the second temperature. C-B indicated the defrost cycle is set for between 4:30 and 5:30 a.m. which can cause higher temperatures in the walk-in refrigerator. On 8/2/16, at 7:39 a.m. the CDM provided a list of foods thrown away because temperatures were above 40 degrees F. The list included cranberry	F 371		

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chicken breasts, roast beef, beef gravy, potatoes salad, Lo Mein noodles, yellow squash, goat cheese, carrot soup, whip topping, shredded roast beef, carrot soup, pumpkin cheesecake, focaccia bread, eight bottles of salad dressing, and a pan of turkey and ham sandwiches.

The director of maintenance (DM) was interviewed on 8/2/16 at 10:35 a.m. The DM stated the technician from MK Mechanical was at the facility that morning and added coolant to the cooling system for the walk-in refrigerator. The age of the walk-in cooler was not known and there was not an equipment manual available. The DM was not aware of a preventative maintenance program for the walk-in refrigerator. The DM indicated he was not informed the temperatures documented for 7/16, were out of range for the walk-in refrigerator.

A Sodexo (contracted company providing dietary services) policy titled HAACP/Food Safety Program Food Safety Standards and Requirements was provided by the CDM. It directed "All refrigeration equipment must be maintained at 40 degrees F." Company Standards and Guidelines indicated refrigeration equipment temperature of 40 degrees F or below must be maintained during stable times. Frequent opening and closing of refrigeration and freezer doors during production may cause the ambient air to rise significantly. The temperature must be checked at least once each day. The policy also directed cold food need to be held at 40 degrees F.

On 8/4/16, at 3:24 p.m. the executive director (ED) was interviewed regarding the walk-in refrigerator. The ED was not aware of the issues

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	245328	A. BUILDING _____ B. WING _____	08/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 37 related to the walk-in refrigerator. The ED stated MK Mechanical was at the facility on 7/8/16, to service the walk-in refrigerator.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		9/9/16

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F 431	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the removal of expired medications on 2 of 4 units in the facility. This resulted in the use of expired Aplisol (used to aid in the diagnosis of tuberculosis exposure) for 8 of 88 residents (R57, R58, R76, R101, R112, R181, R183, R185). Findings include: On 8/4/16, at 7:54 a.m. the Parkside medication room contained an expired bottle of Aplisol. The Aplisol, lot # 795580 was dated received from pharmacy on 6/7/16. The bottle was opened but had not been labeled with the date opened. The TCU (transitional care unit) medication room also had an expired bottle of Aplisol. The Aplisol, lot # 795580 was dated received from pharmacy 6/7/16. The bottle was opened but had not been labeled with the date opened. On 8/4/16, at 7:55 a.m., registered nurse (RN)-A stated she did not know when the bottle was opened but stated she had used it the previous day to administer Mantoux skin tests to staff. During an interview on 8/4/16, at 8:25 a.m., license practical nurse (LPN)-C stated she did not know when the bottle was opened. R57's face sheet indicated he admitted to the facility on 7/9/16. A review of the Margaret S Parmly Residence Immunization Report dated 7/5/16, through 8/4/16, indicated R57 received Mantoux tuberculin skin tests utilizing the Aplisol	F 431	The facility will ensure the removal of expired medications. Policy and Procedure for labeling and storage of medications was reviewed, no changes were made. Staff were provided education on labeling /storage of medications. Ongoing audits to be completed on all units weekly x 4. All expired medications were properly destroyed. A 2 step mantoux was initiated on 8/25/16 for R101. R57, R58, R76, R112, R181, R183, and R185 have all been discharged. DON and/or designee will be responsible for ongoing compliance.	

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F 431	Continued From page 39	F 431		

solution on 7/10/16, and 7/17/16.

R58's face sheet indicated she admitted to the facility on 7/5/16. A review of Margaret S Parmly Residence Immunization Report dated 7/5/16, through 8/4/16, indicated R57 received Mantoux tuberculin skin tests utilizing the Aplisol solution on 7/6/16, and 7/13/16.

R76's face sheet indicated he admitted to the facility on 6/27/16. A review of Margaret S Parmly Residence Immunization Report dated 7/5/16 through 8/4/16, indicated R57 received a Mantoux tuberculin skin test utilizing the Aplisol solution on 7/5/16.

R101's face sheet indicated he admitted to the facility on 7/25/16. A review of Margaret S Parmly Residence Immunization Report dated 7/5/16 through 8/4/16, indicated R57 received a Mantoux tuberculin utilizing the Aplisol solution skin test on 7/26/16.

R112's face sheet indicated he admitted to the facility on 6/26/16. A review of Margaret S Parmly Residence Immunization Report dated 7/5/16, through 8/4/16, indicated R57 received a Mantoux tuberculin skin test utilizing the Aplisol solution on 7/9/16.

R181's face sheet indicated he admitted to the facility on 7/7/16. A review of Margaret S Parmly Residence Immunization Report dated 7/5/16 through 8/4/16, indicated R57 received Mantoux tuberculin skin tests utilizing the Aplisol solution on 7/8/16, and 7/15/16.

R183's face sheet indicated he admitted to the facility on 7/12/16. A review of Margaret S Parmly

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F 431	Continued From page 40 Residence Immunization Report dated 7/5/16, through 8/4/16, indicated R57 received Mantoux tuberculin skin tests utilizing the Aplisol solution on 7/13/16, and 7/20/16. R185's face sheet indicated she admitted to the facility on 7/15/16. A review of Margaret S Parmly Residence Immunization Report dated 7/5/16, through 8/4/16, indicated R57 received Mantoux tuberculin skin tests utilizing the Aplisol solution on 7/16/16, and 7/26/16. A pharmacy review Thrifty White Facility Audit Form dated 7/25/16, indicated the Parkside medication room contained expired Aplisol. On 8/4/16, at 9:34 a.m., the director of nursing (DON) stated the facility is supposed to be auditing for expired medications on the overnight shift. She further stated nurses should be checking the expiration dates of all medications prior to giving them. A facility policy titled Ecumen Labeling/Storage of Medications dated 8/03, indicated no discontinued, outdated or deteriorated medications are available for use in the facility. All such medications are destroyed.	F 431		

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	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

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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 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 The Margaret Parmley Residence building 01 was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/26/2016

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 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and 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 The Margaret Parmley Residence is a 1-story building with a no basement. The building was constructed in 1972, construction Type II(111) with an addition, in 1999, construction Type II(111). Two assisted living buildings are connected and properly fire separated. Therefore, the facility was inspected as two different buildings. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 101 beds and had a census of 90 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 2 - two hour fire separation was found not in compliance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 19.1.1.4.1 and 19.1.1.4.2,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 21 of 90 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 AM to 3:30 PM on 08/03/2016, observations and staff interviews revealed that the fire doors in the 2 hour fire separation that is located near resident room 110 had a 1/4 inch gap between both leaves of the double doors. This deficient condition was verified by a Maintenance Supervisor (DH).	K 011	The 1/4 inch gap revealed in the fire doors near room 110 and the Chapel has been repaired. All fire doors throughout the building were inspected for gaps and were repaired, if necessary. Director of Maintenance and/or designee will be responsible for ongoing compliance.	9/9/16
K 018	NFPA 101 LIFE SAFETY CODE STANDARD	K 018		9/9/16

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K 018 SS=E	Continued From page 3 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had 1 of several corridor doors that did not meet the requirements of NFPA Life Safety Code 101 2000 edition section 19.3.6.3.3. This deficient practice could affect 20 of 90 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 9:30 AM to 3:30 PM on 08/03/2016, it was observed that the following doors have kick down style of unapproved door hold open devices: 1. The Chaplain's Office in the Chapel 2. Room 120B 3. Room 144	K 018	The kick down style door opening devices were all removed from the building. They are replaced with magnetic, quick release door opening devices. All Administrative and Maintenance Staff were educated on the appropriate door opening devices. Director of Maintenance and/or designee will be responsible for ongoing compliance.	

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K 018	Continued From page 4 4. The Beauty Shop This deficient condition was verified by a Maintenance Supervisor (DH).	K 018		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a means of egress in accordance with the following requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 7.1.6.2, 7.2.1.5.1, 7.2.1.5.4, 19.2.1, and 19.2.2.2.4. This deficient practice could affect 90 of 90 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 AM to 3:30 PM on 08/03/2016, observation and staff interviews revealed the following deficient conditions: 1. The doors located by room 175 and 164 are painted to look like a book shelf and can be confused as not being an exit. 2. The exit discharge located at the chapel exit was only equipped with a 4 foot by 6 foot concrete pad and did not have a hard path leading to the public way. 3. The exit door by resident room 110 is equipped with delayed egress door latching hardware and the door is not labeled indicating to depress the panic bar for 15 seconds for the exit door to open.	K 038	The doors that are painted to resemble books shelves have been re painted to clearly identify them as exit doors. The exit door located on the north end of the Chapel is being equipped with a hard path which will extend and lead to a public way. The exit door by room 110 has been appropriately labeled with instructions for using the PANIC bar. An audit of all other exit doors and instruction labels were added as appropriate. Director of Maintenance and/or designee will be responsible for ongoing compliance.	9/9/16

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K 038	Continued From page 5 This deficient condition was verified by a Maintenance Supervisor (DH).	K 038		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4., 19.3.6.3.2, 19.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 90 of 90 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:30 AM to 3:30 PM on 08/03/2016, observations revealed the following deficient condition affecting the fire alarm maintenance: 1. After a review of all available reports and fire alarm maintenance/testing documentation for the last 12 months and an interview with the Maintenance Supervisor, it was revealed that the facility failed to document and/or verify 2 of 12	K 052	The facility will maintain compliance by placing all monthly DACT tests in the electronic preventative maintenance program (TELs), where they will be tracked and stored. The Director of Maintenance will contact All Safe Alarms, who completed the annual inspection of the facility, to provide the complete listing of the facility's fire alarm devices. The smoke detector which was located within 36 inches of an HVAC vent has been relocated. Education has been provided to all Maintenance Staff regarding appropriate placement of smoke detectors. Director of Maintenance and/or designee will be responsible for ongoing compliance.	9/9/16

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K 052	Continued From page 6 monthly tests of the digital alarm communicator transmitter (DACT). 2. After a review of all available reports and fire alarm maintenance/testing documentation for the last 12 months and an interview with the Maintenance Supervisor, it was observed that the facility's fire alarm device inventory was not included within the annual fire alarm test documentation. 3. The is a smoke detector that is located within 36 inches of a HVAC vent. This deficient condition was verified by a Maintenance Supervisor (DH).	K 052		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 90 of 90 residents as well as an undetermined number of staff, and visitors to the facility.	K 062	Sprinkler flow tests will be completed quarterly. Recurring quarterly sprinkler flow testing reminders will be placed in the electronic preventative maintenance program (TELs), where they will be tracked and stored. Director of Maintenance and/or designee will be responsible for ongoing compliance.	9/9/16

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K 062	Continued From page 7 Findings include: On facility tour between 9:30 AM to 3:30 PM on 08/03/2016, a review of documentation and an interview with the Maintenance Supervisor revealed that at the time of the inspection the facility could not provide documentation for 3 of 4 quarterly fire sprinkler flow test verifying that they have been completed. This deficient condition was verified by a Maintenance Supervisor (DH).	K 062		
K 070 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility used portable space heaters in non-resident care areas and failed to provide a policy on the use of portable space heaters in the facility that meets the requirements of NFPA 101 Life Safety Code (00), Section 19.7.8. This deficient practice could affect 40 of 90 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:30 AM to 3:30 PM on 08/03/2016, it was observed that there were an unapproved portable space heaters found in	K 070	All portable heaters in the building were immediately removed. Education has been provided to all Maintenance and Administrative Staff on portable heater use. Director of Maintenance and/or designee will be responsible for ongoing compliance.	9/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

(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 070	Continued From page 8 rooms 105 and 144 in staff member offices. These portable heater are being used in patient non-sleeping areas and the facility could not provide any documentation or policy regulating the use of portable space heating devices within the facility. This deficient condition was verified by a Maintenance Supervisor (DH).	K 070		
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections, 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect 90 of 90 residents as well as an undetermined number of staff, and visitors to the facility in the event of an emergency. Findings include: On facility tour between 9:30 AM to 3:30 PM on 08/03/2016, it was revealed during the review of the facility's emergency generator testing and maintenance logs that the facility did not annotated if they are running their 40 kW generator at 30 percent of the rated capacity. This deficient condition was verified by a	K 144	All Maintenance Staff have been educated and trained on using the electronic display panel to verify percentage of rated capacity during testing. Director of Maintenance and/or designee will be responsible for ongoing compliance.	9/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

(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 144	Continued From page 9 Maintenance Supervisor (DH).	K 144		
K 154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 90 of 90 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 9:30 AM to 3:30 PM on 08/03/2016, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire sprinkler system out of service policy that included the current State Fire Marshal's contact information in the event of the fire sprinkler being out of service and the need for a fire watch to be initiated. This deficient condition was verified by a Maintenance Supervisor (DH).	K 154	Fire Sprinkler System Out Of Service Policy has been updated and posted. Director of Maintenance and/or designee will be responsible for ongoing compliance.	9/9/16
K 155	NFPA 101 LIFE SAFETY CODE STANDARD	K 155		9/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD** **CHISAGO CITY, MN 55013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 155 SS=C	Continued From page 10 Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the Fire Alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 90 of 90 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 9:30 AM to 3:30 PM on 08/03/2016, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire alarm system out of service policy that included the current State Fire Marshal's contact information in the event of the fire sprinkler being out of service and the need for a fire watch to be initiated This deficient condition was verified by a Maintenance Supervisor (DH).	K 155	Fire Alarm System Out Of Service Policy has been updated and posted. Director of Maintenance and/or designee will be responsible for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **02 - THE MARGARET S. PARMLEY RESIDENCE** B. WING _____	**08/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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, The Margaret S. Parmly Residence building 02 was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/26/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **02 - THE MARGARET S. PARMLEY RESIDENCE** B. WING _____	**08/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and 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 This facility will be surveyed as two separate buildings. The 2007 addition is a 2-story building with no basement and was determined to be of Type II(111) construction. The upper floor has 12 resident rooms, and the lower level has a pool and therapy functions. It is properly separated from the original building and an assisted living facility on both levels. The building is fully sprinkler protected. The facility has a fire alarm system, with full corridor smoke detection and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that are interconnect with each other and is transmit to the nurses station. The facility has a licensed capacity of 101 beds	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **02 - THE MARGARET S. PARMLEY RESIDENCE** B. WING _____	**08/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 and had a census of 90 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a means of egress in accordance with the following requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections 7.1.6.2, 7.2.1.5.1, 7.2.1.5.4, 19.2.1, and 18.2.2.2.4. This deficient practice could affect 90 of 90 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:30 AM to 3:30 PM on 08/03/2016, observation and staff interviews revealed the following deficient conditions: 1. The doors located by room 175 and 164 are painted to look like a book shelf and can be confused as not being an exit. 2. The exit discharge located at the chapel exit was only equipped with a 4 foot by 6 foot concrete pad and did not have a hard path leading to the public way. 3. The exit door by resident room 110 is equipped with delayed egress door latching hardware and the door is not labeled indicating to depress the panic bar for 15 seconds for the exit door to open.	K 038	The doors that are painted to resemble books shelves are located in a memory care unit. We are requesting a CMS-2786R waiver for this. The exit door located on the north end of the Chapel is being equipped with a hard path which will extend and lead to a public way. The exit door by room 110 has been appropriately labeled with instructions for using the PANIC bar. An audit of all other exit doors and instruction labels were added as appropriate. Director of Maintenance and/or designee will be responsible for ongoing compliance.	9/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **02 - THE MARGARET S. PARMLEY RESIDENCE** B. WING _____	**08/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013**

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K 038	Continued From page 3 This deficient condition was verified by a Maintenance Supervisor (DH).	K 038		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 18.3.4., 18.3.6.3.2, 18.3.6.3.3, and 9.6, as well as 1999 NFPA 72, Sections 7.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 90 of 90 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:30 AM to 3:30 PM on 08/03/2016, observations revealed the following deficient condition affecting the fire alarm maintenance: 1. after a review of all available reports and fire alarm maintenance/testing documentation for the last 12 months and an interview with the Maintenance Supervisor, it was revealed that the facility failed to document and/or verify 2 of 12	K 052	The facility will maintain compliance by placing all monthly DACT tests in the electronic preventative maintenance program (TELs), where they will be tracked and stored. The Director of Maintenance will contact All Safe Alarms, who completed the annual inspection of the facility, to provide the complete listing of the facility's fire alarm devices. The smoke detector which was located within 36 inches of an HVAC vent has been relocated. Education has been provided to all Maintenance Staff regarding appropriate placement of smoke detectors. Director of Maintenance and/or designee will be responsible for ongoing compliance.	9/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **02 - THE MARGARET S. PARMLEY RESIDENCE** B. WING _____	**08/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013**

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K 052	Continued From page 4 monthly tests of the digital alarm communicator transmitter (DACT). 2. after a review of all available reports and fire alarm maintenance/testing documentation for the last 12 months and an interview with the Maintenance Supervisor, it was observed that the facility's fire alarm device inventory was not included within the annual fire alarm test documentation. 3. The is a smoke detector that is located within 36 inches of a HVAC vent This deficient condition was verified by a Maintenance Supervisor (DH).	K 052		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 18.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 90 of 90 residents as well as an undetermined number of staff, and visitors to the facility.	K 062	Sprinkler flow tests will be completed quarterly. Recurring quarterly sprinkler flow testing reminders will be placed in the electronic preventative maintenance program (TELs), where they will be tracked and stored. Director of Maintenance and/or designee will be responsible for ongoing compliance.	9/9/16

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	245328	A. BUILDING **02 - THE MARGARET S. PARMLEY RESIDENCE** B. WING _____	08/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013**

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K 062	Continued From page 5 Findings include: On facility tour between 9:30 AM to 3:30 PM on 08/03/2016, a review of documentation and an interview with the Maintenance Supervisor revealed that at the time of the inspection the facility could not provide documentation for 3 of 4 quarterly fire sprinkler flow test verifying that they have been completed. This deficient condition was verified by a Maintenance Supervisor (DH).	K 062		
K 070 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility used portable space heaters in non-resident care areas and failed to provide a policy on the use of portable space heaters in the facility that meets the requirements of NFPA 101 Life Safety Code (00), Section 18.7.8. This deficient practice could affect 40 of 90 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 9:30 AM to 3:30 PM on 08/03/2016, it was observed that there were an unapproved portable space heaters found in rooms 105 and 144 in staff member offices.	K 070	All portable heaters in the building were immediately removed. Education has been provided to all Maintenance and Administrative Staff on portable heater use. Director of Maintenance and/or designee will be responsible for ongoing compliance.	9/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **02 - THE MARGARET S. PARMLEY RESIDENCE** B. WING _____	**08/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MARGARET S PARMLY RESIDENCE	**28210 OLD TOWNE ROAD CHISAGO CITY, MN 55013**

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K 070	Continued From page 6 These portable heater are being used in patient non-sleeping areas and the facility could not provide any documentation or policy regulating the use of portable space heating devices within the facility. This deficient condition was verified by a Maintenance Supervisor (DH).	K 070		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2000 edition (LSC) sections, 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect 90 of 90 residents as well as an undetermined number of staff, and visitors to the facility in the event of an emergency. Findings include: On facility tour between 9:30 AM to 3:30 PM on 08/03/2016, it was revealed during the review of the facility's emergency generator testing and maintenance logs that the facility did not annotated if they are running their 40 kW generator at 30 percent of the rated capacity. This deficient condition was verified by a Maintenance Supervisor (DH).	K 144	All Maintenance Staff have been educated and trained on using the electronic display panel to verify percentage of rated capacity during testing. Director of Maintenance and/or designee will be responsible for ongoing compliance.	9/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **02 - THE MARGARET S. PARMLEY RESIDENCE** B. WING _____	**08/03/2016**

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K 154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1. This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 90 of 90 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 9:30 AM to 3:30 PM on 08/03/2016, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire sprinkler system out of service policy that included the current State Fire Marshal's contact information in the event of the fire sprinkler being out of service and the need for a fire watch to be initiated This deficient condition was verified by a Maintenance Supervisor (DH).	K 154	Fire Sprinkler System Out Of Service Policy has been updated and posted. Director of Maintenance and/or designee will be responsible for ongoing compliance.	9/9/16
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of	K 155		9/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245328	A. BUILDING **02 - THE MARGARET S. PARMLEY RESIDENCE** B. WING _____	08/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 155	Continued From page 8 service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the Fire Alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 90 of 90 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 9:30 AM to 3:30 PM on 08/03/2016, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire alarm system out of service policy that included the current State Fire Marshal's contact information in the event of the fire sprinkler being out of service and the need for a fire watch to be initiated This deficient condition was verified by a Maintenance Supervisor (DH).	K 155	Fire Alarm System Out Of Service Policy has been updated and posted. Director of Maintenance and/or designee will be responsible for ongoing compliance.	