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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 4M7S
Facility ID: 00582

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245283**

2. STATE VENDOR OR MEDICAID NO. (L2) **228663700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST MICHAELS HEALTH & REHAB CENTER**
(L4) **1201 8TH STREET SOUTH**
(L5) **VIRGINIA, MN** (L6) **55792**

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 **05/08/2014** (L34)

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

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12.Total Facility Beds **87** (L18)

13.Total Certified Beds **87** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	87			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE NEII 05/08/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 06/25/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **08/01/1985** (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 **05/19/2014** (L33)

DETERMINATION APPROVAL

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

CCN: 24-5238

On May 8, 2014 a Post Certification Revisit (PCR) was completed at this facility and verfied correction of deficiencies issued pursuant to the March 14, 2014 survey, effective April 23, 2014. Refer to the CMS 2567b for the results of this visit.

In addition, the facility requested continuing waiver involving the deficiencies cited under K14, K38, K67 and K103, which has been forwarded to CMS for their review and determination.

Effective April 23, 2014, the facility is certified for 87 skillled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5283

June 25, 2014

Ms. Cheryl High, Administrator
St Michaels Health & Rehabilitation Center
1201 8th Street South
Virginia, Minnesota 55792

Dear Ms. High:

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 April 23, 2014 the above facility is certified for:

87 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 87 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K14, K38, K67 and K103.

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

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

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

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 21, 2014

Ms. Cheryl High, Administrator
St Michaels Health & Rehabilitation Center
1201 8th Street South
Virginia, Minnesota 55792

RE: Project Number S5283024

Dear Ms. High:

On March 28, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 14, 2014. 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 May 8, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 14, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 23, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 14, 2014, effective April 23, 2014 and therefore remedies outlined in our letter to you dated March 28, 2014, will not be imposed.

Your request for a continuing waiver involving the deficiencies cited under K14, K38, K67 and K103 at the time of the March 14, 2014 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

lease 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 eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5283r14epoc.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245283	A. Building B. Wing	5/8/2014

Name of Facility	Street Address, City, State, Zip Code
ST MICHAELS HEALTH & REHAB CENTER	1201 8TH STREET SOUTH VIRGINIA, MN 55792

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

(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	**04/23/2014**
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	**04/23/2014**
ID Prefix **F0165** Reg. # **483.10(f)(1)** LSC	**04/23/2014**
ID Prefix **F0241** Reg. # **483.15(a)** LSC	**04/23/2014**
ID Prefix **F0242** Reg. # **483.15(b)** LSC	**04/23/2014**
ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	**04/23/2014**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**04/23/2014**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	**04/23/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**04/23/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	**04/23/2014**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	**04/23/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	**04/23/2014**
ID Prefix **F0325** Reg. # **483.25(i)** LSC	**04/23/2014**
ID Prefix **F0327** Reg. # **483.25(j)** LSC	**04/23/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	**04/23/2014**

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	MM/PH	05/21/2014	29433	05/08/2014
Reviewed By CMS RO				

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245283	A. Building B. Wing	5/8/2014

Name of Facility	Street Address, City, State, Zip Code
ST MICHAELS HEALTH & REHAB CENTER	1201 8TH STREET SOUTH VIRGINIA, MN 55792

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **04/23/2014**				

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/PH	05/21/2014	29433	05/08/2014

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 3/14/2014

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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 4M7S
Facility ID: 00582

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245283**

2. STATE VENDOR OR MEDICAID NO. (L2) **228663700**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST MICHAELS HEALTH & REHAB CENTER**
(L4) **1201 8TH STREET SOUTH**
(L5) **VIRGINIA, MN** (L6) **55792**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/14/2014** (L34)

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	

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12. Total Facility Beds **87** (L18)

13. Total Certified Beds **87** (L17)

10. THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	87			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE NEII 04/23/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **08/01/1985** (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

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

CCN: 24-5238

On March 14, 2014 a standard survey was completed at this facility. Deficiencies were found, whereby corrections are required. Post Certification Revisit (PCR) to follow. Refer to the CMS 2567 for both health and life safety code along with the provider's plan of correction.

Documentation supporting the facility's request for a continuing waiver of deficiencies cited at K014, K0038, K0067 and K0103 have been previously forwarded. Approval of the waiver requests was recommended.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 28, 2014

Ms. Cheryl High, Administrator
St. Michaels Health & Rehabilitation Center
1201 8th Street South
Virginia, Minnesota 55792

RE: Project Number S5283024

Dear Ms. High:

On March 14, 2014, 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;**

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

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

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

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:

Patricia Halverson, Supervisor
Duluth Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: Patricia.halverson@state.mn.us

Phone: (218) 302-6151
Fax: (218) 340-6623

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 April 23, 2014, 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 April 23, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (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 June 14, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 14, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us

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

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File 5283s14ePOC.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245283	A. BUILDING ______ B. WING ______	03/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MICHAELS HEALTH & REHAB CENTER	**1201 8TH STREET SOUTH VIRGINIA, MN 55792**

(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. Census: 79	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157		4/23/14

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

Electronically Signed — 04/07/2014

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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	245283	A. BUILDING ______ B. WING ______	03/14/2014

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F 157	Continued From page 1 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to promptly notify the physician and the resident's representative for a change in condition for 1 of 3 residents (R16) reviewed for pressure ulcers. Findings include: R16'S Diagnoses Report dated 8/5/13, indicated diagnoses that included essential hypertension, atrial fibrillation, and renal and urethral disorder. The quarterly Minimum Data Set (MDS) dated 12/17/13, indicated R16 had severe cognitive impairment, required extensive assistance with bed mobility, transfers, and personal hygiene activities. The MDS further indicated R16 was at risk for the development of pressure ulcers, currently had no pressure ulcers, and had pressure reducing devices in the chair and bed and application of ointments or medications other than to the feet.	F 157	SMHRC notifies family and physicians of changes in resident status. R16's family and physician were notified of the Pressure Ulcer Event on 3/11/14. The Facility will run a Facility Event Summary Report for Elopements, Falls, and Pressure Ulcers for the period of 3/15/14 to 4/1/2014 to audit for family and physician notification. Should the audit reveal any notifications that were not completed, the family and physician will be notified. The Events Reporting Policy, the Family Notification Policy, and the Physician Notification Policy have been reviewed and revised as appropriate and RNs and LPNs received formal training. A Facility Event Summary Report will be run daily and the IDT will audit the events	

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F 157	Continued From page 2 An Event Report dated 3/9/14, indicated R16 had developed 2 open areas to the coccyx, which measured 0.4 cm by 0.2 cm and 1.5 cm by 0.5 cm. The Report further indicated R16's physician was notified on 3/11/14, at 12:33 p.m. and R16's family was notified on 3/11/14, at 12:33 p.m. On 3/13/14, at 10:40 a.m. registered nurse (RN)-B stated R16 developed stage 2 pressure ulcers on the coccyx on 3/9/14. RN-B confirmed R16's physician and representative should have been notified of the new pressure ulcers on the weekend but were not notified until Tuesday 3/11/14. On 3/14/14, at 2:00 p.m. the director of nursing (DON) stated the facility's policy was to report changes in resident condition to the physician and representative within 24 hours. The DON confirmed R16's new pressure ulcers should have been reported within 24 hours. A Significant Change in Resident Condition or Care policy reviewed and revised 11/6/08, indicated staff would notify the resident's physician and legal representative or family member of any significant changes in condition which demands a significant change in treatment. The policy further indicated the necessary notification would be completed within 24 hours.	F 157	to assure Family and Physician have been notified consistent with facility policy. Monitoring will be completed at a consistent level, (daily) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC. The Director of Nursing is responsible.	
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations,	F 164		4/23/14

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F 164	Continued From page 3 medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provided privacy during insulin administration for 8 of 8 residents (R67, R14, R64, R19, R63, R6, R152, R11). Findings include: R67 was seated in the main lobby area with multiple other residents present on 3/12/14, at 1:15 p.m.. Licensed practical nurse (LPN)-E came to the lobby and was observed to inject insulin in R67's lower abdominal area.	F 164	SMHRC provides personal privacy for residents. R67's insulin will be administered in a private area. R14's accuchecks will be completed in a private area. R64's accuchecks will be completed in a private area. R19's insulin will be administered in a	

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F 164	Continued From page 4 LPN-E, interviewed on 3/12/14, at 1:35 p.m., stated the facility's policy was to ask the resident if it was alright to administer insulin in a public place. LPN-E stated she was familiar with R67 and did not ask R67 for permission every time. LPN-E stated she preferred to give insulin in the lobby over the dining room because there was food in the dining room. A Dignity and Respect policy reviewed and revised 3/27/13, indicated residents' bodies would be examined and treated in a private manner. On 3/12/14, at 7:55 a.m. R14 was going to the dining room for breakfast. LPN-D stopped R14 at the nurse's desk and completed the accucheck (blood sugar check) at the nurses station. R14 was not asked for permission to complete the procedure in public. R14 went into the dining room for breakfast at 8:30 a.m. LPN-D entered the dining room with R14's insulin and asked, "Can I give you a poke out here [in the dining room] or should we go to your room." R14 indicated LPN-D could give the insulin in the dining room. LPN-D gave R14 one insulin injection in the right arm and raised the shirt to administer the second injection in his abdomen. R112 was sitting across the table and was previously complaining of nausea; however, R112 was not asked if watching an injection was acceptable at the dining room table. There were 5 other residents in the dining room at the time. R64 was seated at the dining room table on 3/12/14, at 8:30 a.m. LPN-D did not ask R64 for permission to check blood sugar at the dining room table. R24 was also at the breakfast table at the time.	F 164	private area. R6's inhaler treatments shall be done in a private area. R152's accuchecks will be completed in a private area R63's insulin will be administered in a private area. R11's inhaler treatments shall be done in a private area . R112 and other residents shall not be present during other resident treatments. Clinical Managers will develop a list of resident on their wings who have insulin administration, blood glucose monitoring, and inhaler treatments and assure that those treatments are provided in a private area. The Dignity and Respect Policy, the Medication Administration by Route Policy, the Injections Policy, the Residents Rights Policy, the Insulin Administration Policy, and the Blood Glucose Monitoring Policy have been reviewed and revised. LN's will receive formal training on the updated policies. The Clinical Manager or designee on each unit will complete weekly audits on each unit to assure that the Dignity and Respect, and privacy is maintained. Monitoring will be completed at a	

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F 164	Continued From page 5	F 164		

On 3/12/14 at 1:15 p.m. LPN-D stated "I normally ask their permission before I do an accucheck or insulin." LPN-D indicated if a resident requests privacy it is provided. LPN-D stated she does not ask permission of anyone else in the area, "No I don't ask any table mates or anything - I try to be discreet about it. I know some people are squeamish and stuff."
R19 was given several medications in the main lobby. On 3/12/14, at 7:25 a.m. R19 was seated in the wheel chair in the main lobby when LPN-A was observed to inject insulin in the lower left abdominal area. There were six other residents present at the time, including one resident seated on each side of R19.

On 3/12/14, at 8:01 a.m. R63 was seated in a wheelchair in the main lobby when LPN-A was observed to inject insulin in R63's lower left abdominal area. There were 10 other residents in the immediate area.

R6 was given an inhaler treatment by LPN-A on 3/12/14, at 8:06 a.m. in the main lobby.

On 3/12/14, at 8:18 a.m. R152 was seated in the wheelchair in front of the reception desk at the intersection of the Garden Unit hallway and the entrance to the main dining room. LPN-A completed R152's blood glucose monitoring with several other residents in the area.

On 3/12/14, at 1:22 p.m. LPN-A stated he always did insulins, inhalers and blood glucose check in the lobby or dining room. No on had ever told him the treatments should not be done in public areas.

The director of nurses (DON), interviewed on

consistent level, (weekly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC.

The Director of Nursing will be responsible.

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F 164	Continued From page 6 3/14/14, at 10:30 a.m., stated staff should ask the resident as well as other residents in the area before doing insulin, eye drops and inhalers in public areas. "Blood glucose monitoring is a little iffy. Insulins and blood glucose monitoring could be a dignity issue." R11 was observed to receive an inhaler during the breakfast meal. R11's quarterly minimum data set (MDS) dated 12/11/13, indicated R11 was severely cognitivelly impaired. On 3/12/14, at 8:38 a.m. R11 was seated at the breakfast meal with three tablemates. LPN-A approached R11, handed her a spiriva inhaler, which she proceeded to administer by inhalation.	F 164		
F 165 SS=D	483.10(f)(1) RIGHT TO VOICE GRIEVANCES WITHOUT REPRISAL A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to respond to a written grievance related to after meal care for 1 of 1 residents (R6) reviewed for grievances. Findings include: R6's admission record dated 7/1/13, indicated diagnoses that included cerebral vascular	F 165	R6's concern was addressed and documented in the Customer Concerns log on 1/17/2014. The Care Plan was updated for toileting before and after meals on 2/14/2014. Residents Care Plan indicates goals regarding Wandering. A report was run from the Customer	4/23/14

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F 165	Continued From page 7 disease and dementia. The quarterly Minimum Data Set (MDS) dated 1/6/14, indicated R6 had severe cognitive impairment and required extensive assist of one staff with transfers, wheelchair mobility off the unit and toileting. An undated customer concern feedback form was filled out by family member (FM)-1, indicating that, after breakfast on 1/9/14, R6 was found by a housekeeper lying on another resident's bed. The document indicated that after breakfast on 1/12/14, R6 was found in another resident's room with the door closed. FM-1 indicated she was scared for her mom's safety and asked facility staff to escort R6 back to her room to use the toilet and settle in after breakfast, "If all CNA's are assisting with dining, can the nurses help (LPN, RN). Can you please update our Mom's care plan to show changes needed to keep Mom safe. Thank you." There was no evidence of facility response to the grievance. FM-1, interviewed on 3/12/14, at 2:00 p.m., stated there were many concerns regarding R6 and the family felt they had to be present every day to make sure the care was provided. FM-1 further stated there were communication problems between the family and facility staff. FM-1 stated she felt like she was expected to toilet R6; but FM-1 did not feel she was there as a caregiver. FM-1 stated she talked with the administrator and was told to take her concerns up the chain of command, starting with the nurses on duty at the time of her concerns. On 3/13/14, at 9:34 a.m. the director of nursing (DON) and the director of social service (SS)-A were interviewed. SS-A stated customer concern logs go into the system and whatever department	F 165	Concerns Database for the period 1/1/2014 to 3/31/2014 to check for outstanding concerns and whether the person voicing concern was satisfied with the facility response. All three months showed 100% completion and actions taken. The BHS Service Recovery and Customer Concern Process Policy was reviewed and remains appropriate. Department Managers and RN s were re-educated on the policy. The IDT reviews status of all concerns at A.M. meeting. Social Services and the Administrator are required to sign off and close all concerns. When concerns are not addressed and completed it is dis-approved by either one of these parties and an email is sent to the person who was assigned the concern with further instructions on how to resolve the concern. The concern is not closed in the database until appropriate actions have been completed. The IDT audits the database at A.M. meeting daily (M-F). Monitoring will be completed at a consistent level, (daily M-F) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC. The Administrator is responsible.	

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F 165	Continued From page 8 is responsible is responsible to resolve it. SS- A stated they work with families if the is no resolution with nursing staff. SS-A stated she did not complete individual resident visits and working with R6 was not her job. SS-A was responsible for admissions and MDSs. R6's social service concerns would be addressed by SS-B. The DON verified FM-1 was told to go through the chain of command because she was voicing concerns every day. The DON stated that she talks to family members regarding concerns but R6, "Isn't the only person here." On 3/14/14, at 10:39 p.m. SS-B was interviewed and stated FM-1 was not always receptive to her assistance. SS-B stated she did not document any conversations with FM-1 and there was no care plan to address concerns with FM-1 and R6. Licensed practical nurse (LPN)-A, interviewed on 3/14/14, at 9:15 a.m., stated she provided assistance for R6, but FM-1 does not ask for anything unreasonable. The administrator was not available for interview. The undated facility policy and procedure on concerns and grievances directs the facility assures that after receiving a concern, there is a prompt response by the facility to acknowledge the receipt of the concern, investigate, seek a resolution, and keep the resident appropriately apprised of progress toward resolution.	F 165		
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	F 241		4/23/14

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F 241	Continued From page 9 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 provided a dignified dining experience for 1 of 1 residents (R16) observed during a meal service. Findings include: The quarterly Minimum Data Set (MDS) dated 12/17/13, indicated R16 had severe cognitive impairment, required extensive assistance with eating, and was on a mechanically altered diet. R16's Care Plan dated 8/20/13, directed staff to provide a regular diet with mechanically soft foods, thin liquids in a sippy cup provided by family, and offer a bed time snack per family preference. The nursing assistant Care Plan Reference Sheet dated 1/9/14, indicated R16 required help with eating, was to receive a regular diet with pureed meat and thin liquids with a sippy cup only, used a bent spoon with meals, and set up required. On 3/12/14, at 12:23 p.m. R16 was observed seated in a wheelchair in the dining room. At 12:31 p.m. the spiritual care coordinator (SCC)-I came into the dining room and stood on R16's right side. SCC-I picked up a sippy cup and offered a drink to R16. At 12:32 p.m. nursing assistant (NA)-A brought a bowl of sweet potatoes, a bowl of broccoli and a third bowl of pureed chicken. SCC-I stood beside R16 and	F 241	SMHRC provides dignity and respect of individuality. R16 no longer resides at the facility. Residents who require feeding assistance will be observed by the Culinary Services Manager to assure that staff assisting residents with the need for feeding assistance are seated. The Dining and Food Service Policy was updated and staff who assist with feeding have been trained on the new policy. The Culinary Services Manager or designee will conduct weekly audits by observing all residents who need feeding assistance in both dining rooms to assure that staff assisting residents with feeding are seated. Monitoring will be completed at a consistent level (Weekly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC. The Dietitian is responsible.	

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F 241	Continued From page 10 offered food with a regular handled fork. At 12:39 p.m. licensed practical nurse (LPN)-E entered the dining room and administered several oral medications to R16. At 12:40 p.m. SCC-I remained standing and continued feeding R16 with a regular fork. At 12:48 p.m. SCC-I was observed to go down on one knee for several seconds, then returned to a standing position on the right side of R16's wheelchair. SCC-I used her right hand to feed R16, while the left hand was placed on the right-sided handle on the back of R16's wheelchair. At 1:01 p.m. R16 did not want any more to eat, SCC-I removed the clothing protector and pushed R16 into the lobby area. During the entire meal service, the culinary supervisor (CS)-G was present in the dining room, assisting with the meal service, visiting with the staff and residents in the dining room close to R16's table. On 3/14/14, at 11:50 a.m. CS-G stated SCC-I was a retired LPN. CS-G further stated she had observed SCC-I standing beside R16 during the 3/12/13, lunch meal. CS-G confirmed the SCC-I should have found a chair to sit beside R16 and assist with eating. On 3/14/14, at 12:00 p.m. SCC-I was interviewed via telephone and stated staff assisting a resident to eat should be at head level and should not stand over a resident during the process. SCC-I confirmed standing over R16 during the meal on 3/12/14. On 3/14/14, at 2:00 p.m. the director of nursing (DON) stated staff should be sitting next to residents when assisting at meal times and not standing over them and confirmed this was an undignified practice.	F 241		

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F 241	Continued From page 11 A Dignity and Respect policy reviewed and revised 3/27/13, indicated staff would treat all resident with kindness, dignity, and respect when cares were provided.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide bathing frequency as requested for 1 of 3 residents (R110) reviewed for choices. Findings include: R110's face sheet indicated diagnoses that included dementia, osteoarthritis and macular degeneration. The quarterly minimum data set (MDS) indicated R110 had short and long term memory problems, and severely impaired cognitive skills for daily decision making. The MDS further indicated R110 had no rejection of care behaviors and required extensive assist of one staff for personal hygiene and dressing. The MDS indicated that bathing had not occurred in the lookback period.	F 242	R110's Care Plan will be updated to indicate family preference for bathing. Two residents on each wing will have their Preference for Customary Routine and Activities Observation reviewed and asked their bathing and other preferences. Newly Admitted residents will be asked their preferences during the Preference for Customary Routine and Activities Observation and preferences for bathing and sleeping will be routed to the Clinical Managers to care plan for. Current residents will be asked their preferences during the Preference for Customary Routine and Activities Observation completed with each MDS	4/23/14

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F 242 Continued From page 12

On 3/11/14, at 10:42 a.m. R110's family member (FM)-2 was interviewed and stated R110 was not getting the frequency of bathing requested. FM-2 stated R110 had twice weekly baths but now only once weekly.

R110's care plan dated 8/23/13, directs staff to give R110 a shower or whirlpool bath each week. The kardex, dated 2/28/14, directs staff to give R110 a bath or shower early a.m. before breakfast to decrease anxiety. The facility bath schedule indicated R110's bath day was Thursday.

On 3/13/14, at 9:50 a.m. nursing assistant (NA)-I was interviewed and stated residents can get more than one bath/shower a week if staff have time. NA-I stated if the staff doesn't have time they won't do it. NA-I further stated if a resident asks for more then one shower or bath weekly on a regular basis, they have to speak with the registered nurse (RN).

On 3/13/14, at 9:54 a.m. the director of social services (SS)-A and the director of nursing (DON) were interviewed. SS-A stated residents/family members are asked on admission how often they want a bath or a shower. The DON stated it is discussed at quarterly care conference also.

The care conference notes from 8/8/13, 9/30/13, and 2/14/14, lacked indication of FM-B being asked if bathing/shower frequency was adequate.

On 3/14/14, at 2:58 p.m. the DON verified residents bathing/shower frequency should be honored. The DON further stated the RN should be asking residents/families for bathing/shower frequency preferences, and what days of the

F 242

and changes in bathing and sleeping preferences will be routed to the Clinical Manager for care plan update.

Activities staff and Nursing will be trained on expectations.

Audits will be completed weekly on both the short-term and long-term units to assure that the preferences that were identified during the observation have been care planned for accordingly and are occurring as care planned for.

Monitoring will be completed at a consistent level (Weekly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC.

The Director of Nursing is responsible

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F 242	Continued From page 13 week the resident/family member would like it done. The facility was unable to provide a policy and procedure on choices.	F 242		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced	F 278		4/23/14

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F 278	Continued From page 14 by: Based on observation, interview and document review the facility did not ensure the Minimum Data Set (MDS) was accurate for 1 of 16 residents (R61) whose MDSs were reviewed. Findings include: R61's admission assessment and MDS did not address cognitive status and the 14 day MDS was inaccurately coded for cognitive patterns. R61's diagnoses included muscle weakness with rehabilitation services, dementia, depression and macular degeneration. The admission MDS dated 1/29/14, indicated R61 was able to complete the interview for mental status. R61 had clear speech, was able to understand and was understood by others. No further data was included for the mental status assessment on admission. The 14 day MDS dated 2/4/14, indicated R61's BIMS score was 99. A score of 99 meant R61 was unable to complete the interview. This information was conflicting with the assessment which indicated R61 was able to complete the interview and had moderately impaired cognition. R61 had clear speech, was able to understand and was understood by others. R61 was interviewed on 3/11/14, at 2:00 p.m. and responded appropriately to questions. R61 was also observed and interviewed on 3/12/14, and 3/13/14, and was found to carry on an appropriate conversation. On 3/14/14, at 11:25 a.m. the social worker	F 278	R61's 14-day MDS was modified to incorporate the BIMs Observation that was completed on 1/30/14. The MDS Coordinator will review 5 (Five) MDS' completed between March 1-March 31 to assure that the BIMS assessment is accurately coded in the MDS. If there is a discrepancy a Modified MDS will be submitted to the State. Reimbursement Team Communication will increase from three times per week to five times per week to assure coordination of the ARD dates and interviews/observations. The Social worker will be responsible to assure that the observation information is accurately coded in the MDS. The Director of Social Services will conduct weekly audits to ensure that the BIMS has been completed and is accurately coded in the MDS. The MDS Coordinator will conduct weekly audits to assure that required interviews are completed by the ARD date for MDS'. Monitoring will be completed at a consistent level (Weekly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC. The MDS Coordinator is responsible	

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F 278	Continued From page 15 (SW)-B verified an admission BIMS assessment was not done. SW-B also does the MDS and verified the admission MDS was not completed because the BIMS was not completed. The registered nurse (RN)-C, MDS coordinator, interviewed on 3/14/14, at 11:40 a.m., stated a score of 99 indicated not enough information was provided to complete the MDS. The RN stated that without the BIMs assessment the MDS could not be completed. On 3/14/14, at 11:50 a.m. SW-A stated there should have been a follow up to ensure the assessment was completed.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		4/23/14

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F 279	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a care plan for monitoring the use of Coumadin for 1 of 5 residents (R106) reviewed for unnecessary medications. Findings include: R106's physician's order's dated 1/21/14, included Coumadin (a blood thinner) 4.5 milligrams (mg) on Wednesdays, and 3 mg the rest of the week for a history of pulmonary embolism. The package insert on Coumadin included a warning: bleeding risk. Coumadin can cause major or fatal bleeding, and to instruct patients about preventative measures to minimize the risk of bleeding and to report signs and symptoms of bleeding. The care plan dated 9/18/14, did not address monitoring for potential side effects of Coumadin. On 3/14/14, at 2:57 p.m. the director of nursing was interviewed and stated she would expect there to be a care plan for the use of Coumadin. The facility was unable to provide a policy and procedure on the use of Coumadin.	F 279	R106's Care Plan has been updated to address the risk of bleeding for Coumadin use. The Care Plan of all residents who are receiving anti-coagulant therapy will be reviewed and updated if necessary. An Anticoagulation-Monitoring for Potential Side Effects Policy has been developed and staff trained new protocol. A Order Report by Category Report will be run weekly and any resident with new anticoagulant therapy will have their Care Plan audited to assure that the care plan addresses monitoring for side effects. Monitoring will be completed at a consistent level (Weekly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC. The Director of Nursing is responsible	
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	F 280		4/23/14

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F 280	Continued From page 17 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 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 did not revise the care plan to reflect falls for 1 of 3 residents (R140) reviewed for accidents; and to address facial hair removal and nail care for 1 of 2 residents (R32) reviewed for activities of daily living (ADL)s. include: Findings include: R140's care plan was not revised to address falls. R140 was admitted following a fall at home that resulted in a fracture of the right humerus (upper arm). The admission Minimum Data Set (MDS) dated 1/23/14, indicated R140 was cognitively intact and had no behaviors. The MDS further indicated	F 280	R140 has had a new Fall Risk Assessment completed, his Care Plan and Kardex have been updated to reflect current problem, goals, and interventions. A list of resident with falls between March 15 and April 4, 2014 was developed and their Fall Risk Observation will be reviewed and updated if necessary, the Care Plan and Kardex will be reviewed and updated as appropriate. The Assessment Following a Fall or Significant Incident Policy and the Fall Risk and Post Fall Observation Policy have been revised.	

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F 280	Continued From page 18 R140 required extensive assistance of one staff with transfers, wheelchair mobility, dressing, personal hygiene, bathing and toileting. The MDS indicated R140 sustained a fracture from a fall in the month prior to admission. A fall assessment was completed on 3/6/14, and indicated R140 had a history of falls and remained at high risk for falls. Risk factors included medications, self transfers, narcotic pain medications and dizziness. "Call don't fall!" signs were placed in the room. R140 sustained the following falls: On 1/28/14, at 6:00 p.m. R140's was found on the floor next to the bed. R140 had wheeled himself from the dining room to his room to use the urinal. R140 locked the left wheelchair brake, but not the left side and fell while trying to pull the pants up. R140 sustained a skin tear to the left elbow. R140 was referred to therapy for assessment of anti-rollback wheelchair brakes. On 2/18/14, at 2:07 p.m. R140 fell in his room. R140 stated he turned on the call light but staff did not respond. R140 sustained a large skin tear to the right elbow. Suggested interventions were to answer the call light and place, "Call don't fall!" signs in the room. On 2/18/14, at 11:09 p.m. R140 was found kneeling by the bed. R140 stated he was trying to transfer himself from the wheelchair to the bed. On 2/22/14, at 11:30 p.m. R140 was found on the floor in his room after falling during a self transfer attempt. R140 hit his head and complained of severe back pain after falling backwards. R140 was sent to the emergency room and was found	F 280	All LN s have been trained on the policy revisions and expectations. Audits will be completed Daily to assure that residents with Falls have a current Care Plan addressing Falls and that interventions are listed on the Kardex and remain appropriate. Monitoring will be completed at a consistent level (Daily) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the QC. The Director of Nursing is responsible. R32 has been reassessed for grooming preferences and assistance needed and the Care Plan was updated. Using the CMS 672 Census and Conditions Clinical Managers have reviewed residents who have been identified as needing assistance with bathing for appropriate grooming and resident preference. Care Plans and Kardex has been reviewed and updated as applicable. The Dignity and Respect Policy, Bathing Policy, and Nail Care Policy has been reviewed and revised and staff has been re-educated on these expectations. Random weekly audits will be completed weekly by Clinical Managers or designee to assure that the Dignity and Respect is	

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F 280	Continued From page 19 to have a head contusion and a compression fracture of the T12 vertebra. Suggested interventions included a care plan for toileting, a bowel and bladder study, a commode at bedside for ease of toileting, place a urinal at bedside, call light available at the bed and at the commode, and restorative nursing program to educate on safe transfer to the commode. On 3/13/14, at 9:24 p.m. R140 was observed to have anti-rollback brakes on the wheelchair, a commode in the room, a "Call don't fall!" sign by the head of the bed, and call lights placed by the bed and the commode. At 2:10 p.m. R140 was observed to transfer from the bed to the wheelchair with assist of one staff and a gait belt. R140's interdisciplinary care plan dated 2/11/14, did not address falls. The kardex dated 2/24/14, indicated safety measures of auto-lock wheelchair brakes and a night light in room. The kardex was updated on 3/6/14, and indicated R140 required one assist for transfers, did self transfer, and was at risk for falls. The kardex lacked the interventions of the bedside commode and urinal, call lights on the bed and commode, and the "Call don't fall!" signs. On 3/14/14, at 3:05 p.m. the director of nursing (DON) was interviewed and stated she would expect the care plan to address falls and be updated as needed. The facility policy and procedure on care plan process and review policy revised 1/11, directed the purpose of the resident care plan is to provide individualized care based on the individual's needs and preferences, and the care plan will be developed 21 days after admission and placed in	F 280	maintained. Monitoring will be completed at a consistent level, (weekly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC. The Director of Nursing will be responsible.	

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F 280	Continued From page 20 the resident's medical record. The policy further directed care plans are reviewed with newly identified concerns, and change of goal or interventions. R32's care plan was not revised to include assistance with the removal of facial hair and nail care. The care plan dated 1/22/14, indicated R32 had multiple diagnoses including hip/femur fracture, weakness and diabetes mellitus (DM). The care plan indicated R32 required set up assistance for grooming but the area for shaving was blank. Nail care was to be completed by licensed staff due to the diagnosis of DM. On 3/11/14, at 9:45 a.m. R32 was observed to have long white chin hairs and long finger nails. On 3/12/14, at 1:30 p.m. R32 still had facial hair and the finger nails were jagged. R32 stated she wasn't aware of the facial hair as she could no longer see it. but she did not like to have facial hair. When interviewed on 3/13/14, at 11:20 a.m. NA-E indicated R32 was "pretty independent" with her cares. She further indicated R32 was ready to return home. On 3/14/14 at 12:50 p.m. RN-E stated R32 was independent in grooming and ready to go home, but she would, "Mention it" to staff for bath day.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		4/23/14

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F 282	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the care plan for to identify and assess adequate hydration needs with the monitoring of fluid intake for 1 of 3 residents (R16) reviewed for nutrition. Findings include: A Diagnoses Report dated 8/5/13, indicated R16's diagnoses included essential hypertension, atrial fibrillation, and renal and urethral disorder. R16's Care Area Assessment (CAA) for dehydration/fluid maintenance dated 8/15/13, indicated the CAA was triggered due to R16 had an urinary tract infection (UTI), was on an antibiotic and was had some diarrhea. The CAA further indicated a plan of care (POC) should be initiated for the proper amount of fluids and R16 should be monitored for signs and symptoms of dehydration. R16's quarterly Nutrition Assessment dated 12/13/13, indicated R16 was receiving thin liquids via a sippy cup with daily fluid need approximately 1250 to 1500 cc. The Care Plan for Nutritional Status dated 8/20/13, indicated R16 required thin liquids in a sippy cup. The care plan for dehydration/Fluid Maintenance dated 8/21/13, indicated R16 was at risk of dehydration due to history of a UTI. The Dehydration/Fluid Maintenance Care Plan goal edited 9/25/13, indicated R16 would not exhibit signs of dehydration. The Care Plan approaches dated 8/21/13, directed to encourage fluids to at	F 282	SMHRC provides services per the resident s care plan. R16 is no longer a resident at the facility. A CAA Roster for the past quarter indicates that Dehydration/Fluid Maintenance CAA's were triggered for six (6) residents. These resident's Care Plan will be reviewed and if appropriate placed on Intake monitoring. The Hydration Policy, I & O Policy, and the Fluid at Bedside Policy, the Dining and Food Service Policy, and the Oral Care Policy have been reviewed and revised as necessary. Nursing Staff and Dietary Staff will be trained on policies and documentation of intake. Weekly audits will be completed by Dietitian or designee to assure that the Hydration documentation is completed. Clinical Managers on each unit will complete an audit on at least two residents per week who have Hydration concerns as per the Roster/Sample Matrix for signs and symptoms of dehydration. Monitoring will be completed at a consistent level, (weekly) until compliance is achieved and then monitoring will be completed at a level to maintain	

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F 282	Continued From page 22 least 1500 cc per day. R16's NAR Care Plan Reference Sheet 8/27/13, indicated R16 required assistance to drink thin liquids with a sippy cup. On 3/12/14, at approximately 8:50 a.m. nursing assistant (NA)-A was observed to enter R16's room to assist with morning cares. R16's mouth was observed to be very dry, with peeling and cracked lips, coated tongue and inside of cheeks and lips. R16's oral cavity was also noted to have a very strong, foul odor. NA-A stated she usually cares for R16 and had noticed R16 had a difficult time spitting out the toothpaste when assisted with oral cares/teeth brushing. NA-A was observed to use wet pink foam toothettes with toothpaste to swab out R16's mouth, tongue, teeth, cheek and lip areas. NA-A repeated the procedure several times to remove multiple foul smelling, tan-colored dried skin pieces from R16's mouth. R16's half full water pitcher was noted on the bedside table. NA-A assisted R16 to take sips of water from of a small paper cup. On 3/13/14, at 12:00 p.m. the registered dietician (RD) stated R16 was evaluated monthly for oral intake and then again at the quarterly review. The RD further confirmed R16 was not monitored for intake and output and staff were expected to report any changes in intake to the RD. At 12:00 p.m. registered nurse (RN)-B confirmed R16 was at risk for dehydration due to the diuretic use which started in December. RN-B verified R16 was not being monitored for oral intake and nursing staff should be documenting in weekly progress notes all areas addressed in R16's care plan to include edema, hydration, nutrition, and problems outlined on R16's plan of care.	F 282	compliance as determined by the QC. The Dietitian will be responsible.	

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F 282	Continued From page 23 On 3/14/14, at 2:00 p.m. the director of nursing (DON) stated R16's oral intake should have been monitored along with the edema and response to the ordered diuretic. A Dining and Food Service policy dated 5/20/05, indicated all residents would be monitored to assure adequate amounts of food/fluids were consumed. An Intake and Output policy reviewed and revised 3/27/13, indicated residents' intake and output would be monitored, record, and evaluated when clinically warranted.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility did identify and monitor bruising for 1 of 3 residents (R70) with skin conditions and 1 of 1 residents (R6) with an identified change in condition. Findings include: R70 had multiple bruises on both forearms which were not identified and assessed in a timely manner. R70 was admitted with diagnoses	F 309	R70's bruises have been assessed and are being monitored. Three residents on each wing will have their weekly visual skin observation observed by another LN to assure that there is no bruising that has not yet been reported and identified. Should any concerns be identified and event will be created.	4/23/14

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F 309	Continued From page 24 including peripheral vascular disease, venous insufficiency, and hypotension. The care plan dated 2/14/14, did not identify frequent/at risk bruising. On 3/10/14 at 6:30 p.m. R70 was observed with multiple bruises on both forearms. There were two bruises on the left forearm which were dark blue/purple in color and misshapen, approximately 4.5 cm at the widest point. On the right forearm R70 had two small round bruises approximately 1 cm wide and dark blue/purple in color and a larger bruise approximately 4 cm at the widest point and misshapen. On 3/12/14 at 10:45 a.m. the bruises were observed to be fading. When R70 was asked about the bruising, she stated she wasn't sure but thought they came when her daughter grabbed her arms. She denied discomfort. Registered nurse (RN)-E, interviewed on 3/13/14 at 9:00 a.m. regarding the bruises to R70's forearms, denied knowledge of any bruises. RN-E then assessed the bruising and R70 stated the bruising could be from the incident with her daughter. Nursing assistant (NA)-E stated, on 3/13/14, at 11:20 a.m. that when bruises are identified they should be reported "right away." NA-E also indicated she was aware of the bruising to R70's forearms and thought they had been reported. According to RN-E and the director of nursing (DON) on 3/13/14 at 8:45 a.m. the expectation was for bruises to be immediately reported by the aides. Licensed staff would then review the bruises within 2 hours so they can see if they, "Match up to anything," or are reasonably explained. "If not we do a VA (vulnerable adult)	F 309	The Resident Incident and Reporting Policy, the NA Protocols for Care and Reporting Resident Conditions Policy, and the Bathing Policy have been reviewed and updated. All Nursing staff will receive training on reporting of resident change in condition. The Clinical Manager or designee will complete at least one audit weekly on each wing to visually inspect resident skin for bruising or other skin concerns. Monitoring will be completed at a consistent level, (weekly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC. The Director of Nursing will be responsible. *** R6 is not in need of emergency treatment at this time and continues to be monitored by CNP. The Physician Notification Policy has been updated to include guidelines for severe conditions that do not have an immediate cause known. The IDT will audit the 24 Hour Facility Activity Report daily to identify change in resident conditions that while not emergent may warrant further evaluation and audit to assure that the physician has been made aware of the situation.	

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F 309	Continued From page 25 report." The DON further stated staff should have said something - we never miss [reporting a bruise]." R6's family member (FM)-1, interviewed on 3/12/14, at 2:00 p.m., stated that she reported to staff on 10/3/13, that R6 was ill and needed to go the the emergency room via ambulance. FM-1 stated staff refused to call an ambulance and directed R6 to be taken in FM-1's personal vehicle. R6's admission record dated 7/1/13, indicated diagnoses that included cerebral vascular disease and dementia. The quarterly Minimum Data Set (MDS) dated 1/6/14, indicated R6 had severe cognitive impairment and required extensive assist of one staff with transfers, wheelchair mobility off the unit and toileting. Nursing progress notes on 10/3/13, at 1:56 p.m. indicated R6 was sleepy and had difficulty with transfers and required assist of two staff. FM-1 requested that R6 been seen by her physician. R6's vital signs (VS) were as follows: temperature was 98.9, pulse was 88, respirations were 20, and her blood pressure was 102/78 (slightly low). R6's pupils were reactive to light, her hand grasps were strong and she followed commands. R6 had not had a bowel movement in three days and the nurse practitioner (NP) was contacted. The RN assessment did not address lung sounds, bowel sounds, cognitive status, bladder status or food and fluid status. The NP gave orders to give a suppository the next day, initiate a sleep log, encourage fluids, monitor closely and do VS twice daily. FM-1 stated that R6 would be taken to the ER in 10 minutes if she did not wake up. FM-1 was provided the appropriate documentation and	F 309	Monitoring will be completed at a consistent level, (daily) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC. The Director of Nursing will be responsible.	

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F 309	Continued From page 26 F1 transported R6 to the ER in their private vehicle. Nursing progress notes on 10/3/13, at 9:08 p.m. indicated R6 returned to the facility via ambulance stretcher accompanied by ambulance staff and F1. ER physician's orders included discontinue the Foley catheter on 10/4/13, begin Omnicef (an antibiotic) 300 milligrams twice a day and discontinue risperdal (an antipsychotic medication). The ER progress notes and the physician's orders indicated diagnoses of urinary tract infection and dehydration. On 3/13/14, at 9:54 p.m. the director of nursing (DON) was interviewed and stated that facility policy directed a physician's order be obtained to send a resident to the emergency room via ambulance. The DON stated staff called the NP who would not write an order for ambulance transport because they didn't think R6 needed to be seen in the emergency room. The DON stated staff had followed facility policy by not calling for an ambulance. On 3/14/13, at 2:52 p.m. the DON stated that assessment for an ill resident should include a head to toe assessment including food and fluid status, lung sounds, bowel and bladder status, reviewing of the medication list and recent lab work. The DON verified staff should have completed more assessment for R6. The facility did not provide the requested policy and procedure on sending a resident to the ER. .	F 309		

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F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not provide assistance with facial hair removal or nail care for 2 of 3 residents (R70, R32) reviewed for activities of daily living (ADLs). Findings include: R70's current physician's orders dated 2/14/14, included diagnoses including influenza A, pressure ulcers, and osteoarthritis. The Minimum Data Set (MDS) dated 1/29/14, revealed R70 required set up for grooming and assistance with bathing. R70's care plan was silent/blank related to the removal of facial hair and nail care. When observed on 3/10/14 at 6:30 p.m. R70 had several lengthy facial hairs and her fingernails were very long. R70 stated she used to take care of the facial hairs herself but she, "Can't do it anymore." R70 stated she would trim her own fingernails if she had a clipper. On 3/12/14, at 10:45 a.m. R70 continued to have lengthy facial hairs and long finger nails. R70 stated, "The girls normally do it for me" on bath day. "I like to keep them trimmed up." Nursing assistant (NA)-E, interviewed on 3/13/14, at 11:20 a.m., stated R70 asked for assistance with ADLs as needed. NA-E indicated staff just	F 311	R70 has been reassessed for grooming preferences and assistance needed and the Care Plan updated. R32 has been reassessed for grooming preferences and assistance needed and the Care Plan was updated. Using the CMS 672 Census and Conditions Clinical Managers have reviewed residents who have been identified as needing assistance with bathing for appropriate grooming and resident preference. Care Plans and Kardex has been reviewed and updated as applicable. The Dignity and Respect Policy, Nail Care Policy, and Bathing policy has been reviewed and revised and staff has been re-educated on these expectations. The Clinical Manager or designee on each unit will complete weekly audits on each unit to assure that residents needing assistance are receiving the assistance with ADL's as care planned for and that Dignity and Respect, and privacy is maintained.	4/23/14

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F 311	Continued From page 28 help with her bath and putting on ted socks. On 3/14/14 at 12:45 p.m. registered nurse (RN)-E stated facial hair removal and nail care for women was done on bath days and as needed. The facility policy for "AM Morning Cares" reviewed on 4/9/09, indicated shaving is completed with care planned assistance. The policy did not address nail care. R32 did not receive assistance with facial hair removal or nail care. The plan of care dated 1/22/14, indicated R32 had multiple diagnoses including hip/femur fracture, weakness and diabetes mellitus (DM). The plan of care indicated R32 required set up assistance for grooming, but the area for shaving was blank. Nail care was to be completed by licensed staff due to the diagnosis of DM. On 3/11/14, at 9:45 a.m. R32 was observed to have long white chin hairs and long finger nails. On 3/12/14, at 1:30 p.m. R32 still had facial hair and the finger nails were jagged. R32 stated she wasn't aware of the facial hair as she could no longer see it, but she did not like to have facial hair. When interviewed on 3/13/14, at 11:20 a.m. NA-E indicated R32 was pretty independent with her cares. On 3/14/14, at 12:50 p.m. RN-E stated R32 was, "Independent in grooming," and, "Ready to go home." RN-E stated she would "mention it" to staff for bath day.	F 311	Monitoring will be completed at a consistent level, (weekly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC. The Director of Nursing will be responsible.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		4/23/14

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F 323	Continued From page 29 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 by: Based on observation, interview and document review, the facility failed to reassess and provide appropriate interventions after falls for 2 of 3 residents (R140, R16) reviewed for accidents. Findings include: R140 was admitted for rehabilitation following a fall at home with a fracture of the right humerus (upper arm). The admission Minimum Data Set (MDS) dated 1/23/14, indicated R140 was cognitively intact, had no behaviors, required extensive assistance of one staff with transfers, wheelchair mobility, dressing, personal hygiene, bathing and toileting. The MDS also indicated R140 had a fall with fracture in the month prior to admission. The unsigned and undated falls Care Area Assessment (CAA) indicated R140 fell on 1/28/14, while trying to pull up his pants after using the urinal. The CAA directed falls be a part of the care plan to provide for resident safety. The care plan dated 2/11/14, did not address the risk or history of falls. The kardex dated 2/24/14, indicated safety measures of auto-lock wheelchair brakes and a night light in room. The	F 323	R140 has had a new Fall Risk Assessment completed, his Care Plan and Kardex have been updated to reflect current problem, goals, and interventions. R16 no longer resides at the facility. A list of resident with falls between March 15 and April 4, 2014 was developed and their Fall Risk Observation will be reviewed and updated if necessary, the Care Plan and Kardex will be reviewed and updated as appropriate. The Assessment Following a Fall or Significant Incident Policy and the Fall Risk and Post Fall Observation Policy have been revised. All LN's have been trained on the policy revisions and expectations. Audits will be completed Daily to assure that residents with Falls have a current Care Plan addressing Falls and that interventions are listed on the Kardex and remain appropriate. Clinical Manager or designee will complete daily audits on their units to	

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F 323	Continued From page 30 kardex was updated on 3/6/14, to indicated a risk for falls, self transfers and one assist for transfers. The kardex did not indicate current interventions the commode and urinal at the bedside, the call lights at the bed and commode, and the use of the, "Call don't fall" signage. R140's fall risk assessment was dated 3/6/14, 37 days after R140's first fall in the facility. The fall risk assessment indicated R140 had a history of falls and remained at high risk for falls. The assessment further indicated R140 had a diuretic for edema, self transfers, had a narcotic pain reliever and had dizziness. "Call don't fall!" signs were placed in the room. R140 sustained the following falls: On 1/28/14, at 6:00 p.m. R140 was found on the floor next to the bed. R140 had wheeled himself from the dining room to use the urinal. He locked the left brake on the wheelchair but not the right side. After using the urinal, R140 fell while attempting to pull his pants up and sustained a skin tear to the left elbow. The facility intervention was to have therapy assess for possible anti-rollback brakes on the wheelchair. On 2/18/14, at 2:07 p.m. R140 fell in his room. Staff asked why he did not use the call light, and R140 answered he did, but staff never answered it. R140 sustained a large skin tear to the right elbow. The facility interventions were to talk with staff about answering his light, and place "Call don't fall" signs in his room. There was no evidence to indicate the lack of call light response was investigated as part of the falls root cause analysis. On 2/18/14, at 11:09 p.m. R140 was found	F 323	assure that the Plan of Care is being implemented and followed as care planned for. Monitoring will be completed at a consistent level (Daily) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the QC. The Director of Nursing is responsible.	

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F 323	Continued From page 31 kneeling by the bed. R140 stated he was trying to transfer himself from the wheelchair to the bed, then fell. The facility interventions was to place "Call don't fall" signs in the room. On 2/22/14, at 11:30 p.m. R140 was found on the floor in his room after a self transfer attempt. R140 fell backwards hitting his head and complaining of pain in the middle of his back. R140 was transported to the emergency room and was diagnosed with a head contusion and a compression fracture of the T12 vertebra. Suggested interventions were to review the care plan for toileting, implement a bowel and bladder study, place a commode at bedside for ease of toileting, place a urinal at bedside, have a call light available at the bed and at the commode, and have the restorative nursing program work with him to educate on safe transfer to the commode. On 3/13/14, at 9:24 p.m. R140 was observed to have anti-rollback brakes on the wheelchair, a commode in the room, a "Call don't fall" sign by the head of the bed, and call lights placed by the bed and the commode. At 2:10 p.m. R140 was observed to transfer from the bed to the wheelchair with assist of one staff and a gait belt. On 3/14/14, at 3:05 p.m. the director of nursing (DON) was interviewed and stated she would expect the care plan to address falls, and interventions should be updated as needed. The DON stated the facility does a root cause analysis after falls, but she had not looked at R140's room, and was not sure if the interventions were in place. The facility policy and procedure on fall risk and	F 323		

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F 323	Continued From page 32	F 323		

post fall assessments dated 8/02, directed the fall risk assessment is to be completed upon admission, with significant changes, annually or as deemed by nursing. Residents with risk for falling are care planned accordingly, and residents that have a fall are re-evaluated for therapeutic interventions by the interdisciplinary team within 24 hours or as soon as practical.

R16 was not reassessed with the most recent three falls.

The quarterly Minimum Data Set (MDS) dated 12/17/13, indicated R16 had severe cognitive impairment, required extensive assistance with bed mobility, transfers, locomotion on and off the unit, toileting, and personal hygiene activities. The MDS further indicated R16 had not fallen since admission or since the last assessment.

R16's Admission Fall Risk Assessment dated 8/2/13, indicated a risk for falls due to intermittent confusion; poor recall, judgement and safety awareness; visual impairment; required the use of assistive devices; and had impaired mobility with a need for assisted toileting. R16 was receiving an antidepressant and an antihypertensive medications, had a history of falls in the last 3 months, and had a change in neuromuscular function and change in cognitive status. The Fall Risk Assessment dated 9/25/13, indicated R16 was at risk for falls, required the assistance of 1 staff for transfers, had diminished safety awareness, attempted self transfers and history of previous falls. The Assessment indicated R16's care plan was updated to include toileting right after dinner and a night light placed in the room at night.

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F 323	Continued From page 33 R16's Care Plan dated 8/21/13, indicated a history of falls with goal dated 9/25/13, indicating R16 would remain free from further falls/injury. The Care Plan approaches dated 10/2/13, indicated R16 would have a high/low bed with mats on the floor. The Care Plan approaches dated 8/21/13, indicated R16's call light and personal items would be within reach at all times and the room free of clutter; PT/OT [physical therapy/occupational therapy] recommendations for strength training, toning, positioning, transfer training, gait training, and mobility devices would be obtained; and toileting and ADL [activities of daily living] assistance as needed/scheduled would be provided. R16's Kardex (nursing assistant care plan reference sheet dated 9/17/13, indicated under "safety" R16 would have bed lowered to the floor, mats on the floor, auto-lock breaks on wheelchair (dated 10/7/13), night light at night, and wheelchair next to recliner when up in recliner. R16 had falls on 2/10/14, 2/11/14, and 2/23/14, all of which occurred in the earlier morning hours when R16 got out of bed and was found next to the bed on the floor. R16's medical record lacked evidence a Fall Risk Assessment had been completed, or R16's Care Plan had been revised or updated. On 3/12/14, at 9:00 a.m. nursing assistant (NA)-A was observed to transfer R16 from the bed to the wheelchair after providing morning cares. NA-A removed the blue floor mat next to R16's bed and raised the bed to a higher position for care provision. NA-A assisted R16 to a seated position, applied a transfer belt around R16's mid-section, lowered the bed to a mid-level position, and assisted R16 to stand and pivot into	F 323		

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F 323	Continued From page 34 the adjacent wheelchair. At approximately 9:30 a.m. NA-A stated R16 required assistance with all cares and does bear some weight while transferring. On 3/14/14, at 4:00 p.m. registered nurse (RN)-B stated R16 had multiple falls when first admitted to the facility. RN-B confirmed R16 should have been reassessed when R16 was falling again in 2/1014. There should have been a root-cause analysis to review R16's falls. On 3/14/14, at 4:15 p.m. the DON stated R16 should have been reassessed in 2/2014, for root-cause analysis of the falls, and if needed, revise R16's plan of care.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to promptly identify and assess weight loss for 1 of 3 residents (R16) reviewed for nutrition.	F 325	R16 no longer resides at the facility. A Weight Variance Report will be run from Matrix and the Dietician will review all	4/23/14

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F 325	Continued From page 35 Findings include: R16's Diagnoses Report dated 8/5/13, indicated diagnoses including essential hypertension, atrial fibrillation, and renal and urethral disorder. The quarterly Minimum Data Set (MDS) dated 12/17/13, indicated R16 had severe cognitive impairment, required extensive assistance with eating, was on a mechanically altered diet with no problems swallowing or nutritional status, and had no weight loss. R16's Care Area Assessment (CAA) dated 8/15/13, indicated R16 had several functional problems affecting eating ability which included a swallowing problem, an inability to perform activities of daily living (ADL's) without significant physical assistance, vision problems, and the need for a special diet or altered consistency which might not appeal to R16. The CAA further identified several cognitive, mental status or behavior problems which included cognitive loss, very slow eating and poor memory. The CAA also included an analysis of findings which included R16 was receiving a mechanically altered texture of food and fluid, was upgraded with fluids going to nectar thickened even though R16 preferred thin liquids, snack preference in the evening was fruit, did not drink milk, and with an occupational therapy (OT) evaluation, R16 did not require the use of built up utensils. The CAA directed staff to proceed to the Care Plan due to less than desired meal intake. R16's quarterly Nutrition Assessment dated 12/13/13, indicated R16 was receiving a regular, mechanically-soft texture diet due to dentition,	F 325	residents for significant weight loss. Those identified with weight loss will have their care plans updated with new interventions. The Weight Monitoring and Documentation Policy, the Weight Tracking Policy, the Monitoring Residents at Nutritional Risk Policy, and the Significant Weight Loss Policy have been reviewed and revised as appropriate. The Dietitian, CDM, LN's, and NAR s will be educated on policies. The Culinary Services Manager will audit the Weight Variance Report monthly and cross reference with Dietitian to assure that interventions have been implemented. Monitoring will be completed at a consistent level, (monthly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC. The Dietitian will be responsible.	

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F 325	Continued From page 36	F 325		

with thin liquids via a sippy cup. The assessment further indicated R16's current weight was 106 pounds, was stable, with the goal body weight of 110 lbs +/- 10%. The assessment also indicated R16 had no swallowing disorder, required partial or total feeding assistance and total assistance with adaptive equipment, and had been meeting nutritional needs without the use of supplement, and was lactose intolerant.

The Care Plan dated 8/20/13, indicated R16 had impaired chewing and swallowing and did not drink fluid milk. The Care Plan goal edited 9/25/13, indicated R16 would consume 50% of meals and maintain weight at ~ 109 pounds. Approaches dated 8/20/13, included a regular diet with mechanically soft foods, thin liquids in a sippy cup, and offer a bedtime snack per family preference.

R16's NAR Care Plan Reference Sheet 8/27/13, indicated R16 was to receive a regular diet with pureed meat (dated 1/9/14), thin liquids with a sippy cup only, a bent spoon with meals and required set up and assistance with eating.

Review of R16's weights indicated the following:
On 9/10/13, weight of 104 pounds
On 12/10/13, weight of 106 pounds
On 2/11/14, weight of 98 pounds
On 2/25/14, weight of 95 pounds
No weight documented for the week of 3/3/14
On 3/11/14, weight of 93 pounds

On 3/12/14, from 12:23 p.m. to 12:58 p.m. and on 3/13/14, from 8:30 a.m. to approximately 9:00 a.m. R16 was observed in the dining room to be assisted appropriately with eating. R16's fluids were provided using covered sippy cups.

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F 325	Continued From page 37 On 3/12/14, R16 consumed approximately 1 full sippy cup of watered down apple juice and approximately 50% of cooked broccoli, cooked sweet potato, and pureed chicken, and approximately 25% of a dessert cup. On 3/13/14, R16 consumed approximately 1 full sippy cup of fluids, approximately 75% of hot cereal, a few bites of toast, no egg, no banana. At approximately 9:00 a.m. nursing assistant (NA)-G stated R16's intake is not recorded as there is no red placemat at R16's table signaling staff to record the oral intake, percentage of meal eaten or fluids consumed during each meal. NA-G further stated R16 was seated at the restorative table, where feeding assistance was provided and residents are evaluated for their feeding needs. The registered dietician (RD), interviewed on 3/13/14, at 12:00 p.m. stated R16 was evaluated monthly for oral intake and at the quarterly review. The RD stated weekly weights were evaluated on all residents and confirmed R16's weight of 95 pounds was missed in February. The RD further confirmed R16 was not monitored for intake and output and staff were expected to report any changes in intake to the RD. The RD verified residents with the red placemat at the resident's usual table place indicated intake was to be monitored and recorded in a dietary book located in the dining room kitchenette area. The RD confirmed R16's intake was not being monitored or recorded in the book. The RD stated that if R16's weight loss had been identified in February, some sort of intervention would have been implemented at that time.	F 325		

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F 325	Continued From page 38 On 3/14/14, at 2:00 p.m. the director of nursing (DON) stated R16's weight loss should have been identified and oral intake should have been monitored along with the edema and response to the ordered diuretic. A Meal Service by Nursing policy dated 10/12/05, indicated nursing staff was responsible to record meal intake as directed by their supervisors and less than 25% meal intake was to be reported to the licensed staff member. A Dining and Food Service policy dated 5/20/05, indicated all residents would be monitored to assure adequate amounts of food/fluids were consumed.	F 325		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate hydration was provided and fluid intake was monitored for 1 of 1 residents (R16) reviewed for nutrition. Findings include: A Diagnoses Report dated 8/5/13, indicated R16's diagnoses included essential hypertension, atrial fibrillation, and renal and urethral disorder. The quarterly Minimum Data Set (MDS) dated 12/17/13, indicated R16 had severe cognitive	F 327	R16 is no longer a resident at the facility. A CAA Roster for the past quarter indicates that Dehydration/Fluid Maintenance CAA's were triggered for six (6) residents. These resident s Care Plan will be reviewed and if appropriate placed on Intake monitoring. The Hydration Policy, I & O Policy, and the Fluid at Bedside Policy, the Dining and Food Service Policy, and the Oral Care Policy have been reviewed and revised as necessary.	4/23/14

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F 327	Continued From page 39 impairment, required extensive assistance with eating, was on a mechanically altered diet with no problems swallowing or nutritional status, and had no weight loss. R16's Care Area Assessment (CAA) for dehydration/fluid maintenance dated 8/15/13, indicated the CAA was triggered due to R16 had an urinary tract infection (UTI), was on an antibiotic and was had some diarrhea. The CAA further indicated a plan of care (POC) should be initiated for the proper amount of fluids and R16 should be monitored for signs and symptoms of dehydration. R16's quarterly Nutrition Assessment dated 12/13/13, indicated R16 was receiving thin liquids via a sippy cup. The assessment further indicated R16's current weight was 106 pounds and the estimated daily fluid need was approximately 1250 to 1500 cc. The Assessment also indicated R16 had no swallowing disorder and required partial or total feeding assistance. R16's Care Plan for Nutritional Status dated 8/20/13, indicated R16 had impaired chewing and swallowing. R16 required thin liquids in a sippy cup. The care plan for dehydration/Fluid Maintenance dated 8/21/13, indicated R16 was at risk of dehydration due to history of a UTI. The Dehydration/Fluid Maintenance Care Plan goal edited 9/25/13, indicated R16 would not exhibit signs of dehydration. The Care Plan approaches dated 8/21/13, directed to encourage fluids to at least 1500 cc per day, unless contraindicated. R16's NAR Care Plan Reference Sheet 8/27/13, indicated R16 required assistance to drink thin liquids with a sippy cup.	F 327	Nursing Staff and Dietary Staff will be trained on policies and documentation of intake. Weekly audits will be completed by Dietitian or designee to assure that the Hydration documentation is completed. Clinical Managers on each unit will complete an audit on at least two residents per week who have Hydration concerns as per the Roster/Sample Matrix for signs and symptoms of dehydration. Monitoring will be completed at a consistent level, (weekly) until compliance is achieved and then monitoring will be completed at a level to maintain compliance as determined by the QC. The Dietitian will be responsible.	

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On 3/12/14, at approximately 8:50 a.m. nursing assistant (NA)-A was observed to enter R16's room to assist with morning cares. R16's mouth was observed to be very dry, with peeling and cracked lips, coated tongue and inside of cheeks and lips. R16's oral cavity was also noted to have a very strong, foul odor. NA-A stated she usually cares for R16 and had noticed R16 had a difficult time spitting out the toothpaste when assisted with oral cares/teeth brushing. NA-A was observed to use wet pink foam toothettes with toothpaste to swab out R16's mouth, tongue, teeth, cheek and lip areas. NA-A repeated the procedure several times to remove multiple foul smelling, tan-colored dried skin pieces from R16's mouth. R16's half full water pitcher was noted on the bedside table. NA-A assisted R16 to take sips of water from of a small paper cup.

Review of the electronic progress notes dated 12/18/13 indicated R16's family member had called with concern about R16 having lower extremity edema.

R16's electronic Medication Administration Records (eMAR) for 12/2013, 1/2014, 2/2014, and 3/2014 directed nursing staff to assess edema, behaviors, pain, and skin issues along with weekly vital signs. R16's eMAR's for 1/2014, were signed off to indicate an assessment was completed and documented; however, there was no corresponding progress not on 1/13/14, or 1/27/14. The eMAR entry dated 1/20/14, indicated the assessment was not completed due to time constraints. The eMAR's for 2/2014, were signed off to indicate an assessment was completed and documented; however, there was no corresponding progress note for 2/10/14, and

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F 327	Continued From page 41 2/24/14. The eMAR's for 3/2014, were signed off on 3/3/14, and 3/10/14; with no documented progress note on 3/10/14. On 3/12/14, from 12:23 p.m. to 12:58 p.m. and on 3/13/14, from 8:30 a.m. to approximately 9:00 a.m. R16 was observed in the dining room to be assisted appropriately with eating. R16's fluids were provided using covered sippy cups. On 3/12/14, at 12:58 p.m., R16 consumed approximately 1 full sippy cup of watered down apple juice. On 3/13/14, at 9:00 a.m., R16 was observed to be attempting to independently consume fluids from a covered sippy cup while seated in the wheelchair at the table in the main dining room. During the 3/13/14, breakfast meal service, R16 consumed approximately 1 full sippy cup of fluids. At approximately 9:00 a.m. nursing assistant (NA)-G stated R16's intake was not recorded because there was no red placemat at R16's table signaling staff to record the oral intake, percentage of meal eaten or fluids consumed during each meal. NA-G further stated R16 is seated at the restorative table, where feeding assistance is provided and residents are evaluated for their feeding needs. On 3/13/14, at 12:00 p.m. the registered dietician (RD) stated R16 was evaluated monthly for oral intake and then again at the quarterly review. The RD further confirmed R16 was not monitored for intake and output and staff were expected to report any changes in intake to the RD. The RD confirmed R16's intake was not being monitored or recorded. At 12:00 p.m. registered nurse (RN)-B confirmed R16 was at risk for dehydration due to the diuretic use which started in December. RN-B verified R16 was not being	F 327		

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F 327	Continued From page 42 monitored for oral intake and nursing staff should be documenting in weekly progress notes all areas addressed in R16's care plan to include edema, hydration, nutrition, and problems outlined on R16's plan of care. On 3/14/14, at 2:00 p.m. the director of nursing (DON) stated R16's oral intake should have been monitored along with the edema and response to the ordered diuretic. A Dining and Food Service policy dated 5/20/05, indicated all residents would be monitored to assure adequate amounts of food/fluids were consumed. An Intake and Output policy reviewed and revised 3/27/13, indicated residents' intake and output would be monitored, record, and evaluated when clinically warranted.	F 327		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441		4/23/14

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(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

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

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review the facility did not ensure proper hand hygiene was provided during dressing changes for 2 of 3 residents (R70, R19).

Findings include:

Licensed staff did not utilize appropriate hand hygiene during R70's dressing change.

R70 had multiple diagnoses including influenza A, pressure ulcers, and osteoarthritis. A physician's order dated 3/11/14, directed dressing changes to a pressure ulcer twice a day. Progress notes indicated R70 was identified with active influenza A on 3/7/14 and placed in droplet precaution isolation that required the use of personal

F 441 — Provider's plan of correction:

St. Michael's Health and Rehabilitation Center maintains infection control processes and policies to assure a safe environment and prevent the spread of infection.

R70 has not suffered any ill effects due to the break in infection and is no longer in isolation.

R19 has not suffered any ill effects due to the break in infection control.

The facility has no one in isolation at this time.

The Dressing Change Policy was

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protective equipment (PPE).

On 3/12/14, at 10:30 a.m. licensed practical nurse (LPN)-C completed a dressing change to R70's pressure ulcer. In between glove changes, when hand sanitizing was required, LPN-C reached behind the PPE (gown) into the pocket of her scrubs for hand sanitizer. LPN-C sanitized her hands each time and returned the bottle to the pocket in her scrubs. At 11:30 a.m. LPN-C stated she understood the concern of contaminating her scrubs and the hand sanitizer leaving the room. LPN-C indicated staff reviewed the option of placing a bottle of hand sanitizer with a pump on it in with R70's dressing change supplies, but ruled it out as it couldn't be removed from the room.

3/14/14 at 1:15 p.m. registered nurse (RN)-D stated staff were expected to use the appropriate PPE when in the room of a resident under infection control precautions. Review of the facility policy for "Hand Washing" and "Isolation Procedures" revealed neither policy addressed the use of hand sanitizer in a room requiring droplet precautions.
R19's diagnoses included type 1 diabetes, left hip fracture, adult failure to thrive, anemia and muscle weakness. The Kardex dated 2/4/14, indicated R19 had a stage two pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer) on the heel and the coccyx.

On 3/13/14, at 11:20 a.m. LPN-A was observed to provide a dressing change and ulcer care for R19's pressure ulcers. R19 was positioned on her back in bed. LPN-A gathered supplies from R19's night stand and assembled the supplies on the over bed table. LPN-A washed hands in R19's

reviewed and revised. The Hand Washing Policy was reviewed and remains appropriate.

All RNs and LPNs will be observed completing a dressing change by the Infection Preventionist or designee for skill competency.

The Clinical Manager or designee will complete daily audits of Nursing staff for compliance with infection control policies and procedures including hand-washing and dressing changes.

Monitoring will be completed at a consistent level (Daily) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the QC.

The Infection Preventionist or designee will complete weekly audits of non-nursing staff for compliance with infection control policies and procedures.

Monitoring will be completed at a consistent level (Weekly) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the QC.

The Infection Preventionist is responsible for monitoring

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MICHAELS HEALTH & REHAB CENTER	1201 8TH STREET SOUTH VIRGINIA, MN 55792

(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 441	Continued From page 45 bathroom and applied gloves. LPN-A opened the incontinent brief, assisted R19 to roll onto the left side and removed the coccyx dressing. LPN-A then removed a blue boot from R19's left foot and removed the left heel dressing. LPN-A cleansed the heel wound and then the coccyx ulcer with wound cleanser. LPN-A then removed the gloves, washed hands and applied new gloves. LPN-A applied Isosorb to the dressing, applied the dressing to the coccyx, fastened the brief, washed hands and donned clean gloves. LPN-A applied a Primapore dressing to the left heel, covered the dressing with an Allevyn heel cup, applied R19's sock and fastened the boot. LPN-A removed the gloves and washed his hands. On 3/13/14, at 2:15 p.m. LPN-A was interviewed and stated each wound should have been treated separately. LPN-a stated the gloves should have been changed before cleaning each wound. On 3/14/14, at 10:30 a.m. the director of nursing (DON) stated staff should be washing their hands at the beginning and the end and when changing gloves. The DON verified the wounds should have been treated separately and gloves should be changed whenever going from dirty to clean. The facility's Dressing Change Clean and Sterile policy revised on 5/31/13, directed staff to remove the soiled gloves after removing the soiled dressing, wash their hands and don new gloves.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465		4/23/14

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F 465

Continued From page 46
residents, staff and the public.

This REQUIREMENT is not met as evidenced by:
Based on observation interview and document review the facility failed to ensure that resident rooms were maintained in a sanitary and homelike manner for 23 of 79 residents (R106, R19, R98, R93, R140, R31, R18, R59, R141, R110, R61, R5, R90, R92, R155, R51, R78, R1, R57, R16, R37, R70, R13) related to worn non skid strips in bathrooms, scrapes on the doors and walls in resident rooms and bathrooms, torn fall mats and unclean surfaces in bathrooms and floors.

Findings include:

The facility lacked a system to identify and repair environmental issues in resident rooms.

On 3/14/14, at 9:30 a.m. during an environmental tour with the maintenance director (MD) the following was noted;

R106's room floor surface was dingy and dark colored around the edges of the room. In the bathroom the non skid strips on the floor in front of the toilet were worn with pieces missing.

R19's fall mat on the floor on the outside of the bed was torn open on each end exposing the foam and the fall mat on the floor between the bed and the wall was torn open on the corners and had a piece missing on the center edge exposing the foam. The nonskid strips in front of the toilet were worn with areas missing. On the bathroom sink wood counter top, the front was

F 465

(R106) The floor in Room 33 was stripped and re-waxed, and the skid strips in the bathroom were re-painted.

(R19's) fall mats were replaced. In room 3: The skid strips were repaired, the wood in front of the bathroom countertop and the door was sanded and stained, and the wall between the bathroom and the closet was painted.

(R31 and R98) In room 44 the doors were patched and sanded, the skid strips were removed.

(R93) The walls in room 40 were painted and the skid strips were re-painted.

(R140) The floor in room 17 was stripped and re-waxed.

(R18) The floor and bathroom floor in room 19 were stripped and re-waxed.

(R59) The bathroom floor in Room 38 was stripped and re-waxed. The non-skid strips were replaced. The loose strips were removed from transfer bar, the toilet seat was replaced, the bathroom door was patched and stained , the foot board on the bed was replaced.

(R141) The bathroom door in room 55 was patched and stained , and the

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F 465	Continued From page 47 scraped exposing rough wood. The bathroom door was scraped and missing pieces of veneer on the inner and outer lower edges. The wall between the bathroom and the closet was scraped with several black marks. R98's bathroom door was scratched and had pieces missing on the lower half of the door. The lower edge of the closet door was scraped and the finish was worn off. The nonskid strips on the floor in front of the toilet had edges lifting up and areas missing. R93's room had scrapes and black marks on the wall. In the bathroom the non skid strips on the floor in front of the toilet were worn with pieces missing. R140's room floor was marred and worn. R31's bathroom door was scraped and with gouges at the bottom of the door. The nonskid strips on the floor in front of the toilet had edges lifting up. R18's room and bathroom floors were a dingy gray color with a black build up around the edge. R59's bathroom floor behind the toilet was dirty with black build up in the corners, the nonskid strips on the floor in front of the toilet were worn and soiled with the edges lifting up. The transfer bar on the wall next to the toilet had non skid tape wrapped around it and the upper end was peeling up. The bracket attaching the transfer bars to the toilet was rusty. The transfer bars attached to the toilet had a brown foam strap with a Velcro end on the right side and sheep skin secured with gray duct tape on both transfer bars. The	F 465	horizontal window blind was repaired. (R110) The affected areas on the room walls in room 12 were patched and painted, the bathroom door was patched and stained. (R61) The bathroom door in Room 36 was patched and stained, the countertop wood was sanded and stained, the bathroom floor was stripped and re-waxed, and the wall in the bathroom was patched and painted in the affected areas. The bed pan and urinal were stored appropriately. (R5) The bathroom door in room 8 was patched and stained. (R90) The bathroom door in room 51 was patched and stained. The affected area to the bathroom wall was patched and painted. (R92) The bathroom floor in room 14 was stripped and re-waxed. (R155) The wet areas on the wall near the ceiling were cut out, patched, and painted. (R51) The room and bathroom floors in Room 2 were stripped and re-waxed. The faucet was repaired, the bathroom door was patched and stained. (R78) The floor in room 19 was stripped and re-waxed. (R1) The wall paper near the head of the	

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F 465	Continued From page 48 bathroom door was scratched on the inner lower portion and was chipped exposing rough wood. The bottom corner of R59's bed's footboard was chipped exposing rough wood. R141's bathroom door was scratched and chipped on the lower edge. The horizontal window blind was missing one slat which was standing in the corner of the room. R110's room walls were scuffed and the bathroom door was chipped. R61's bathroom door was chipped exposing rough wood. The edges of the bathroom floor had a dark build up with more in the corners behind the toilet. Scratches were noted on the wall next tot he toilet. On the bathroom sink wood counter top, the front was scraped exposing rough wood. There was a empty bed pan and urinal on the floor under the sink in the bathroom. R5's bathroom door was chipped on the lower outer edge exposing rough wood. R90's bathroom wall near the sink and the lower portion of the bathroom door was scratched. R92's bathroom floor was a dingy gray color with a black build up around the edge. R155's room ceiling had two wet looking areas with a soft area under them that appeared to have been painted over. R51's room and bathroom floor edges had a black build up. The bathroom faucet was dripping. The bathroom door's outer edge was chipped and had scratches on the bottom inner	F 465	bed in Room 37 was replaced. (R57) The toilet seat in Room 53 was replaced. (R16) The bathroom door in room 40 was patched and stained. (R37) The floor in room 18 was stripped and re-waxed. (R70) A cross bar was added to the transfer bars in room 71 to stabilized the bars. (R13) The overbed table in room 41 was replaced. All residents using floor mats have had their mats replaced with newly purchased mats. A sample of rooms, those consisting of bedrooms that have tiled floors in the main bedroom will be surveyed for maintenance concerns and will have repairs made. A policy was developed for Housekeeping Room Cleaning to include monitoring for maintenance and sanitation issues. A policy was developed for Maintenance Repair and Notification. Staff will be trained on this process. A policy was developed for Urinal Storage and the Bed Pan Policy was updated. The Director of Housekeeping will complete a weekly audit on one room per	

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F 465	Continued From page 49 corner. R78's room floor in the entrance was scuffed. R1's room had scratches in the wall paper on the wall near the head of the bed. R57's toilet transfer bars had peeling white paint on the handles. R16's bathroom door was scraped and gouged. R37's room floors appeared worn and dirty with a wax build up around the edges of the room. R70's transfer bars next to the toilet were loose and moved when touched. R13's over bed table was worn and had rough edges. On 3/14/14, at 9:30 a.m. during the tour, the MD stated staff should be writing up repair slips and putting them into the maintenance mail box at the reception desk in the lobby. Maintenance checks the mail box several times a day and prioritizes what needs to be done. The MD stated there was not a system to check the resident rooms on a routine basis. The facility had extra fall mats and tray tables and staff can come and get one if it needs to be replaced. At 10:00 a.m. the dietician, stated she has been responsible for housekeeping for about two and a half to three weeks. The dietitician did not have and was not aware of a routine schedule of monitoring resident areas needing housekeeping services.	F 465	week in which a complete room cleaning was done to assure that issues have been reported and for proper storage of Urinals and Bed Pans. Monitoring will be completed at a consistent level (Weekly) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the QC. The Safety Committee will conduct Quarterly Safety Checks which includes observations for safety and sanitation concerns. Monitoring will be completed at a consistent level (Quarterly) until compliance is achieved. Then monitoring will be completed at a level to maintain compliance as determined by the QC. The Administrator is responsible for	

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F 465	Continued From page 50 A policy regarding resident room monitoring and maintenance was requested. The facility provided a (not dated) Life Safety Quarterly Inspection: Wing Rounds checklist which included resident rooms and bathrooms.	F 465		

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

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	245283	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/12/2014**

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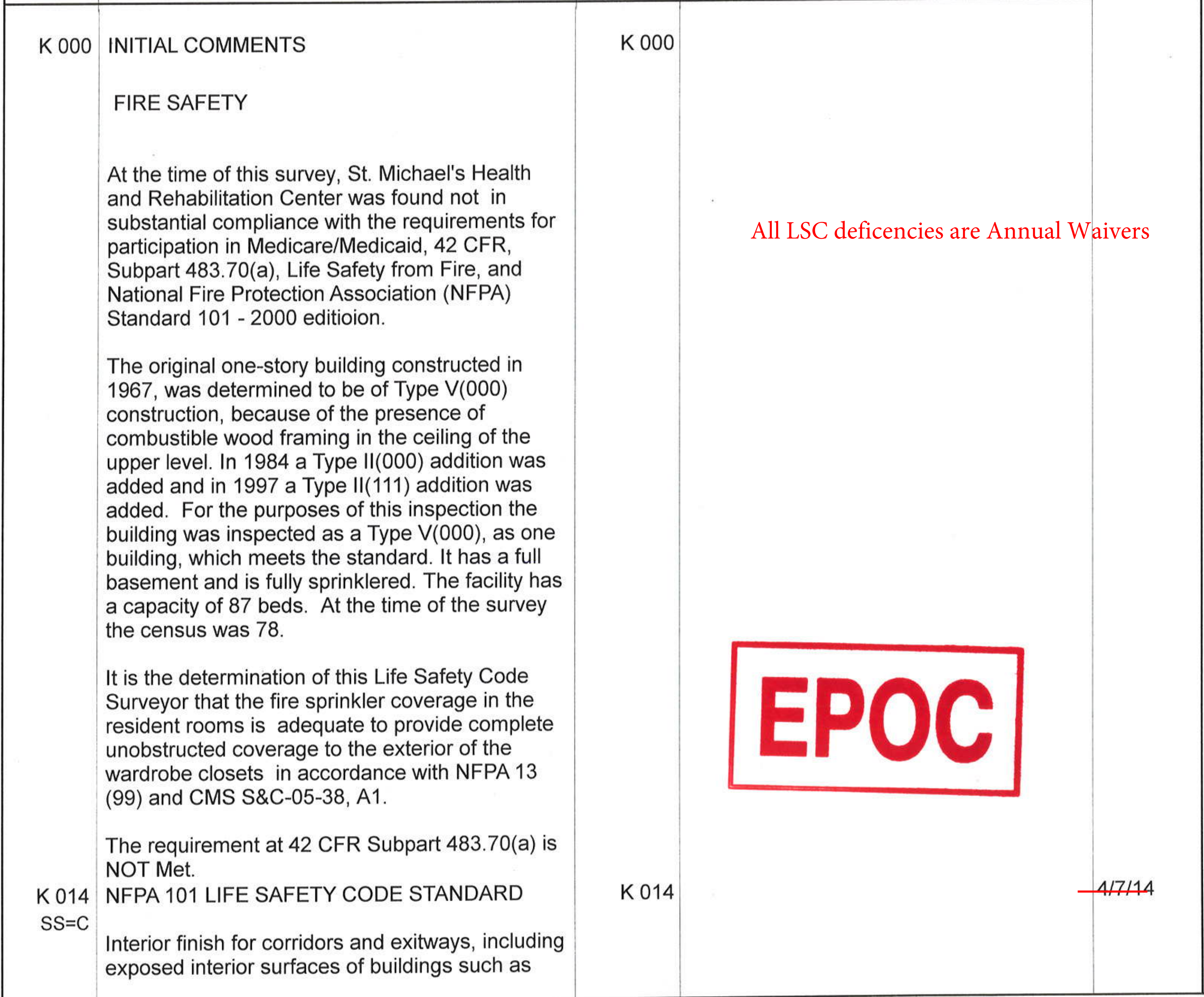

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K 000	INITIAL COMMENTS FIRE SAFETY At the time of this survey, St. Michael's Health and Rehabilitation Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.70(a), Life Safety from Fire, and National Fire Protection Association (NFPA) Standard 101 - 2000 editioion. The original one-story building constructed in 1967, was determined to be of Type V(000) construction, because of the presence of combustible wood framing in the ceiling of the upper level. In 1984 a Type II(000) addition was added and in 1997 a Type II(111) addition was added. For the purposes of this inspection the building was inspected as a Type V(000), as one building, which meets the standard. It has a full basement and is fully sprinklered. The facility has a capacity of 87 beds. At the time of the survey the census was 78. It is the determination of this Life Safety Code Surveyor that the fire sprinkler coverage in the resident rooms is adequate to provide complete unobstructed coverage to the exterior of the wardrobe closets in accordance with NFPA 13 (99) and CMS S&C-05-38, A1. The requirement at 42 CFR Subpart 483.70(a) is NOT Met.	K 000	All LSC deficencies are Annual Waivers EPOC	
K 014 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as	K 014		~~4/7/14~~

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/07/2014

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 014	Continued From page 1 fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observation and documentation, (from FMS Survey dated 3-19-13) the facility failed to provided interior finish materials that meets LSC(00) 19.3.3.1, 19.3.3.2, and 10.2.3. This deficient practice could effect all 87 residents. Findings include: During the facility tour on 3-12-14 between 8:00-10:00AM it was observed that carpet has been applied to the corridor walls on both levels, within 12 inches of the floor. This observation was cited by Federal Surveyor (BW) on 3-19-13. At the time of POC on 5-28-13, the facility had corrected this condition throughout the "C" wing, and plans to continue as carpet is replaced at normal intervals. This deficient practice was confirmed by the Director of Maintenance (RC) at the time of exit. ***** Annual Waiver Recommended ***	K 014	Waiver requested (CMS-2786R to be mailed to MN State Fire Marshal Division)	
K 038 SS=C	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	K 038		~~4/7/14~~

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K 038	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and documentation (from FMS Survey dated 3-19-13) the facility failed to provided proper means of egress from the basement storage area under the "A" wing, in accordance with LSC(00) section 19-2-1. This deficient practice could effect all occupants (undermined number) that would need to evacuate this area in an emergency. Note: residents are not allowed in this area. Findings include: During the facility tour on 3-12-14 between 8:00-10:00AM it was observed that the storage area in the basement, under the "A" wing, only has one exit. This area is approximately 7, 290 square feet in size. Rooms over 2,500 square feet require two remote exits. This observation was cited by Federal Surveyor (BW) on 3-19-13 as a part of an FMS. This deficient practice was confirmed by the Director of Maintenance (RC) at the time of exit. **Annual Waiver Recommended***	K 038	Waiver requested (CMS-2786R to be mailed to MN State Fire Marshal Division)	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067		~~4/7/14~~

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K 067	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation, interview, and documentation (from FMS Survey dated 3-19-13) the facility failed to install heating and ventilation in accordance with LSC(00) section 19-5.2.1 and NFPA 90A 19.5.2.2. This deficient practice could effect all residents. Findings include: During the facility tour on 3-12-14 between 8:00-10:00AM it was observed and confirmed by interview, with the Director of Maintenance (RC) the the corridor is being used as a return air plenum in the "A & B" wings. This observation was cited by Federal Surveyor (BW) on 3-19-13. Interview with the Director of Maintenance (RC) indicated that the facility has not pursued a plan of correction based on the estimated cost of the project. This deficient practice was confirmed by the Director of Maintenance (RC) at the time of exit. ***Annual Waiver Recommended***	K 067	Waiver requested (CMS-2786R to be mailed to MN State Fire Marshal Division)	
K 103 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3 This STANDARD is not met as evidenced by: Based on observation, interview, and	K 103	Waiver requested (CMS-2786R to be	~~4/7/14~~

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K 103	Continued From page 4 documentation (from FMS Survey dated 3-19-13) the facility failed to install non-combustible framing, above the ceiling, in two locations. The building was originally constructed as non-combustible Type II(111) per LSC(00) 19.1.6.3. This deficient practice could effect 30 of the 97 residents. Findings include: During the facility tour on 3-12-14 between 8:00-10:00AM it was observed that in two areas above the ceiling in tub rooms of "A & B" wings limited combustible framing material has been used. This observation was cited by Federal Surveyor (BW) on 3-19-13. Based on interview with the facility Director of Maintenance (RC), this condition still exists. This deficient practice was confirmed by the Director of Maintenance (RC) at the time of exit. ***Annual Waiver Recommended***	K 103	mailed to MN State Fire Marshal Division)	

Sheehan, Pat (DPS)

From:	Sheehan, Pat (DPS)
Sent:	Wednesday, April 09, 2014 11:48 AM
To:	'rochi_lsc@cms.hhs.gov'
Cc:	jeffrey.juntunen@state.mn.us; 'cheri.high@bhshealth.org'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject:	St Michaels Health & Rehab Center (245282) K14, K38, K67 & K103 Annual Waiver Requests - Previously Approved - No Changes

This is to inform you that St Michael's H&R (using ePOC) is requesting an annual waiver for K's 14,38,67 & 103 that were created during an FMS dated 3-19-13 and subsequently approved by CMS. The exit date was 3-12-14.

I am recommending that CMS again approve these waiver requests.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Name of Facility
St. Michael's Health and Rehabilitation Center

2000 CODE
24-5283

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K014	An annual/continuing waiver is being requested for K014 A. Compliance with this provision will cause an unreasonable hardship because: 1. The most recent cost estimate dated 4-19-13 for removing and replacing the carpet cove on the upper and lower floors is approximately $14000. Due to past years financial losses and a year-to-date loss at the facility, the facility has no reserves. 2. Removal of the carpeting without replacement of some type of wall covering would make it aesthetically unappealing and could cause injury to residents due to rough surfaces. 3. The carpeting in the A and B wings and lower level is older and is due to be replaced in the next couple of years. The Foundation is currently attempting to raise funds for flooring but do not have adequate funds at this time. 4. The Minnesota Department of Public Safety, State Fire Marshall's Division has allowed installation of carpeting on walls up to a height of 12 inches when the building is fully sprinkled and the carpeting has a Class I rating, based on the Radiant Panel Test for carpeting. These conditions are met at this facility. B. There would be no adverse effect on the building occupants safety because: 1. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFAP13. 2. The existing HVAC System ventilation fans automatically shut down upon activation of the fire alarm system, detection of smoke in the HVAC System, or activation of the sprinkler system. 3. The Building is equipped with corridor smoke detection. 4. On one of the three wings, resident sleeping rooms are equipped with hard-wired single station smoke detectors. 5. The facility is smoke free and signs to that effect are prominently posted at all major entrances. 6. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm, sprinkler system, portable extinguishers). 7. The building fire alarm system is monitored to provide automatic fire department notification. 8. Fire Safety Training is provided for all employees annually and during orientation for all new hires. 9. Fire Drills are conducted at least quarterly on each shift. 10. This annual/continuing waiver has been approved in the past. [signature] 4-6-14

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* [signature]	Title Fire Safety Supervisor	Office State Fire Marshal	Date 4-9-14

Name of Facility **2000 CODE**

St. Michael's Health and Rehabilitation Center 24-5283

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K038	An annual/continuing waiver is being requested for K038 A. Compliance with this provision will cause an unreasonable hardship because: 1. The most recent cost estimate dated 4-8-13 for complying with a second means of egress from this wing is over $113000.00. Due to past years financial losses and a year-to-date loss at the facility, the facility has no reserves. 2. There are concerns that penetrations of load bearing walls to install a second means of egress could adversely affect the structural integrity of the building. B. There would be no adverse effect on the building occupants safety because: 1. Residents do not have access to this area. 2. Not more than two staff members occupy the area at any given time and then only for short periods of time (less than 15 minutes) to stock or retrieve supplies. 3. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFAP13. 4. The existing HVAC System ventilation fans automatically shut down upon activation of the fire alarm system, detection of smoke in the HVAC System, or activation of the sprinkler system. 5. The Building is equipped with corridor smoke detection. 6. This area is equipped with smoke detection. 7. The facility is smoke free and signs to that effect are prominently posted at all major entrances. 8. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm, sprinkler system, portable extinguishers). 9. The building fire alarm system is monitored to provide automatic fire department notification. 10. Fire Safety Training is provided for all employees annually and during orientation for all new hires. 11. Fire Drills are conducted at least quarterly on each shift. 12. The facility will decrease the combustible load of the space and monitor the area to keep combustible load reasonable for the storage space. [signature] 4-6-14

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)* [signature]	Title Fire Safety Supervisor	Office State Fire Marshal	Date 4-9-14

Name of Facility | **2000 CODE**

St. Michael's Health and Rehabilitation Center | 24-5283

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K067	An annual/continuing waiver is being requested for K067

A. Compliance with this provision will cause an unreasonable hardship because:
1. The most recent cost estimate dated 4-10-13 for a complying ducted HVAC system is over $130000.00 excluding the required wiring. Due to past years financial losses and a year-to-date loss at the facility, the facility has no reserves.
2. There are concerns that penetrations of load bearing walls to install required duct work could adversely affect the structural integrity of the building.
3. Installation of a ducted system may require asbestos abatement which would increase the costs.
4. LSC (00), Sec. 9.2.1 gives AHJ the authority to allow existing HVAC systems that do not comply with NFPA 90A to be continued in service.

B. There would be no adverse effect on the building occupants safety because:
1. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFAP13.
2. The existing HVAC System ventilation fans automatically shut down upon activation of the fire alarm system, detection of smoke in the HVAC System, or activation of the sprinkler system.
3. The Building is equipped with corridor smoke detection.
4. On one of the three wings, resident sleeping rooms are equipped with hard-wired single station smoke detectors.
5. The facility is smoke free and signs to that effect are prominently posted at all major entrances.
6. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm, sprinkler system, portable extinguishers).
7. The building fire alarm system is monitored to provide automatic fire department notification.
8. Fire Safety Training is provided for all employees annually and during orientation for all new hires.
9. Fire Drills are conducted at least quarterly on each shift.
10. This annual/continuing waiver has been approved in the past.

[signature] 4-6-14

Surveyor (Signature)	Title	Office	Date
Fire Authority Official (Signature) [signature]	Title Fire Safety Supervisor	Office State Fire Marshal	Date 4-9-14

Name of Facility **2000 CODE**

St. Michael's Health and Rehabilitation Center 24-5283

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K103	An annual/continuing waiver is being requested for K103. A. Compliance with this provision will cause an unreasonable hardship because: 1. The cost of removing the wood framing and replacing the ceilings at the A-Wing and B-Wing tub rooms is estimated at roughly $10,000. 2. NFPA 101(00), Sec. 4.6.3 allows the authority having jurisdiction to modify the requirements of the Code for existing buildings in cases where their application would be impractical. St. Michael's Health & Rehab Center feels that it would be impractical to remove/replace the combustible wood framing at the ceilings because while not in literal compliance with the Code, the combustible wood framing at the ceilings does not represent a significant threat to the safety of the staff and residents and correction of this deficiency would cause the need for disproportionate effort, expense and disruption of services with little or no increase in life safety. B. There would be no adverse effect on the building occupants safety because: 1. The building is protected throughout by a complete supervised automatic sprinkler system installed in accordance with NFAP13. 2. The existing HVAC System ventilation fans automatically shut down upon activation of the fire alarm system, detection of smoke in the HVAC System, or activation of the sprinkler system. 3. The Building is equipped with corridor smoke detection. 4. On one of the three wings, resident sleeping rooms are equipped with hard-wired single station smoke detectors. 5. The facility is smoke free and signs to that effect are prominently posted at all major entrances. 6. Annual service and maintenance contracts exist to service all the facility's fire protection systems (e.g. fire alarm, sprinkler system, portable extinguishers). 7. The building fire alarm system is monitored to provide automatic fire department notification. 8. Fire Safety Training is provided for all employees annually and during orientation for all new hires. 9. Fire Drills are conducted at least quarterly on each shift. 4-6-14

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title Fire Safety Supervisor	Office State Fire Marshal	Date 4-9-14