#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 5L8E

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART	I - TO BE COM	PLETED BY T	THE STAT	E SURVEY	Y AGE	NCY		Facility ID: 00109
2.STATE VENDOR OR MEDICAID NO. (L4) <b>410 WEST MAI</b> (L2) <b>668340100</b> (L5) <b>OSAKIS, MN</b>				MEMORIAL HOME				4. TYPE OF ACTION  1. Initial  3. Termination  5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNIG	ERSHIP	7. PROVIDER/SUP	PLIER CATEGOR	Y 09 ESRD	<u>-02</u> 13 PTIP	(L7)	22 CLIA	7. On-Site Visit  8. Full Survey After (	9. Other Complaint
6. DATE OF SURVEY 06/05 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	/ <b>2014</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPI			FISCAL YEAR ENDIN	G DATE: (L35)
2 AOA 3 Other		V15.11	00 01 1/61		10110011				
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY I	IS CERTIFIED AS:						
From (a):  To (b):  X A. In Compliance With  Program Requirements Compliance Based On:				3. 24 Hour RN 7. Medic				of Services Limit	
2.Total Facility Beds 50 (L18)1. Acceptable POC					RN (Rural SNF) afety Code	8. Patient Room 9. Beds/Room	Size		
13.Total Certified Beds	<b>50</b> (L17)		pliance with Program ents and/or Applied		* Code:	A	A, 5*	(L12)	
14. LTC CERTIFIED BED BREAKDOWN					15. FACILIT	ГҮ МЕЕ	ETS		
18 SNF 18/19 SNF 50	19 SNF	ICF	IID		1861 (e) (	(1) or 18	61 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMARKS	(IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):						
See Attached Remarks									
17. SURVEYOR SIGNATURE		Date :			18. STATE	SURVE	EY AGENCY API	PROVAL	Date:
Marilyn Kaelke, HFE N	VE II		07/18/2014	(L19)	Kate J	ohns	Ton, Enfo	rcement Special	ist 09/12/2014 (L20
	PART II - TO	BE COMPLETEI	D BY HCFA R	EGIONAI	OFFICE (	OR SI	NGLE STAT	E AGENCY	
19. DETERMINATION OF ELIGIBILITY			PLIANCE WITH O	CIVIL	21.	2. Ow	nership/Control I	al Solvency (HCFA-2572) nterest Disclosure Stmt (HC	FA-1513)
<ul><li>X 1. Facility is Eligible to Partic</li><li>2. Facility is not Eligible</li></ul>	pate					3. Bo	th of the Above :		
21, -1g	(L21)								
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 2	4. LTC AGREEMI	ENT	26. TERM	IINATI(	ON ACTION:		(L30)
OF PARTICIPATION <b>04/01/1987</b>	BEGINNING I	DATE	ENDING DAT	Е	VOLUNTA 01-Merger,		00		VTARY Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisf	faction V	W/ Reimbursemer	at 06-Fail to !	Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVE A. Suspension of				03-Risk of I		ry Termination Withdrawal		er Status Change
(L27)	B. Rescind Sus	pension Date:	(L44) (L45)					00-Active	
28. TERMINATION DATE:	20	. INTERMEDIARY/CA			30. REMAI	RKS			
20. TERMINATION DATE.	2)		andden ivo.		30. REMIT	icito			
	(L28)	03001		(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION C	OF APPROVAL DA	TE					
	(L32)			(L33)	DETERM	MINAT	TON APPRO	VAL	

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00109

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

Page 2

Provider Number: 24-5465

Item 16 Continuation for CMS-1539

At the time of the extended survey completed 04/17/14, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required as evidenced by the attached CMS-2567. The facility's request for a continuing waiver involving the deficiency cited at K67 has been recommended.

On 06/05/2014 the Department of Health conducted a Post Certification Revisit (PCR) and on 07/18/2014 the Department of Public Safety conducted an FMS PCR to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective 07/18/2014, the facility is certified for 50 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245465

September 2, 2014

Mr. David Carlson, Administrator Community Memorial Home 410 West Main Street Osakis, MN 56360

Dear Mr. Carlson:

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 July 18, 2014 the above facility is certified for or recommended for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

We have recommended CMS approve the waiver that you requested for the following Life Safety Code Requirements: K067 - corridors as a plenum.

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

Community Memorial Home September 2, 2014 Page 2

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245465

September 2, 2014

Mr. David Carlson, Administrator Community Memorial Home 410 West Main Street Osakis, MN 56360

Dear Mr. Carlson:

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 July 18, 2014 the above facility is certified for or recommended for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility beds.

We have recommended CMS approve the waiver that you requested for the following Life Safety Code Requirements: K067 - corridors as a plenum.

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

Community Memorial Home September 2, 2014 Page 2

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist Licensing and Certification Program Division of Compliance Monitoring

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

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 245465	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 6/5/2014
Name	of Facility		Street Address, City, State, Zip Code	
COMMUNITY MEMORIAL HOME			410 WEST MAIN STREET OSAKIS, MN 56360	

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) I	Item	(Y5)	Date	(Y4)	Item	(Y	′5) E	Date
		Correction				Correction					Correction
ID Deefin	F0000	Completed		D Danfis	F0005	Completed		ID Deefin	F0000		Completed
ID Prefix		_05/16/2014	"	D Prefix		_05/16/2014		ID Prefix			_05/16/2014
Reg. # LSC	483.13(b), 483.13(c)(1)(i)	_		Reg. # LSC	483.13(c)(1)(ii)-(iii), (c)(2)	_			483.13(c)		-
		-		LSC			-	LSC			-
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix	F0250	05/16/2014	II	D Prefix	F0280	06/03/2014		ID Prefix	F0282		06/03/2014
Reg. #	483.15(g)(1)	_		Reg.#	483.20(d)(3), 483.10(k)(2)				483.20(k)(3)(ii)		
LSC		-		LSC		_		LSC			-
		Correction				Correction					Correction
ID Prefix	F0309	Completed <b>06/03/2014</b>	11	D Prefix	F0490	Completed <b>05/16/2014</b>		ID Prefix	F0520		Completed <b>05/16/2014</b>
Reg.#	483.25	_		Reg. #	483.75	_		Rea #	483.75(o)(1)		_
		_				_					_
							+-				
		Correction				Correction					Correction
ID Deefin		Completed		D Danfis		Completed		ID Deefin			Completed
ID Prefix		_	"			_					-
Reg. #		_		Reg. #		_		Reg. #	-		-
		-				_	-				-
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix		_	11	D Prefix		_		ID Prefix			_
Reg. #		_		Reg.#		_		Reg. #			_
LSC		-		LSC				LSC			-
Reviewed By	Reviewed	Ву	Date	:	Signature of Surve	eyor:				Date:	
State Agency	,	JS/KJ	09/	/02/20	14	27	955			06/0	5/2014
Reviewed By	Reviewed	Ву	Date	:	Signature of Surve	eyor:				Date:	
CMS RO											
Followup to	Survey Completed on:				Check for any	Uncorrected	Defici	encies. Was	a Summary of		
	4/17/2014				Uncorrecte	ed Deficiencie	s (CMS	S-2567) Sent	to the Facility?	YES	NO

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 245465	(Y2) Multiple Construction A. Building B. Wing 01 - MAI	N BUILDING 01	(Y3) Date of Revisit 7/18/2014
Name of Facility		Street Address, City, State, Zip Code	
COMMUNITY MEMORIAL HOME		410 WEST MAIN STREET OSAKIS. MN 56360	

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).

Correction   Completed   Com	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4	) Item		(Y5)	Date
D Prefix				Correction					Correction					Correction
Reg. # NFPA 101														
LSC   K0011	ID Prefix			07/17/2014		ID Prefix			07/17/2014		ID Prefix			07/17/2014
Correction   Completed   Completed   Completed   Completed   Completed   Completed   Completed   Completed   O7/17/2014   ID Prefix   O7/17/2014   Reg. # NFPA 101   Reg. # R	ū					-					_			
Completed   D Prefix   Prefix   D Prefix	LSC	K0011			<u> </u>	LSC	K0018				LSC	K0050		_
Completed   D Prefix   Prefix   D Prefix														
D Prefix   D Prefix   Prefix   D D Prefix   D Prefix   D D D D D D D D D D D D D D D D D D														
Reg. # NFPA 101	ID Prefix			•		ID Prefix			•		ID Prefix			
LSC   K0052	Rea.#	NFPA 101		=					-		Rea.#	NFPA 101		
Correction   Completed   ID Prefix   Reg. #   LSC   LSC   LSC   Correction   Completed   ID Prefix   Reg. #   LSC   LS	-					-					_			_
Completed   ID Prefix					-				•	+				
ID Prefix				Correction					Correction					Correction
Reg. # LSC				Completed					Completed					Completed
LSC	ID Prefix			-		ID Prefix			-		ID Prefix			
Correction   Completed   ID Prefix   Reg. #   LSC   Completed   ID Prefix   Reg. #   LSC   Correction   Completed   ID Prefix   Reg. #   LSC   Completed   ID Prefix   Reg. #   LSC   Correction   Completed   ID Prefix   Reg. #   LSC   Completed   ID Prefix   Reg.	-													_
Completed   ID Prefix	LSC				<u> </u>	LSC					LSC			
Completed   ID Prefix														
ID Prefix														
Reg. #	ID Prefix					ID Prefix					ID Prefix			Completed
LSC														_
Correction Completed  ID Prefix Reg. # LSC  Reviewed By PS/KJ Reviewed By Revi	-								-		LSC			
Completed    D Prefix					-				•	+				
Reg. # Reg. # Reg. # LSC				Correction					Correction					Correction
Reg. #														
Reviewed By Reviewed By Date: Signature of Surveyor: Date:  State Agency PS/KJ 09/02/2014 27200 07/18/2014  Reviewed By Reviewed By Date: Signature of Surveyor: Date:  CMS RO Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies.	ID Prefix			-		ID Prefix			-		ID Prefix			_
Reviewed By Reviewed By Date: Signature of Surveyor: Date:  State Agency PS/KJ 09/02/2014 27200 07/18/2014  Reviewed By Reviewed By Date: Signature of Surveyor: Date:  CMS RO	_								=		Reg. #			
State Agency PS/KJ 09/02/2014 27200 07/18/2014  Reviewed By Reviewed By Date: Signature of Surveyor: Date:  CMS RO  Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS 3567) Sout to the Escilit?	LSC					LSC					LSC			
State Agency PS/KJ 09/02/2014 27200 07/18/2014  Reviewed By Reviewed By Date: Signature of Surveyor: Date:  CMS RO  Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS 3567) Sout to the Escilit?														
Reviewed By Reviewed By Date: Signature of Surveyor: Date:  CMS RO  Followup to Survey Completed on: Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS 3567) Sout to the Facility?	Reviewed By	·	Reviewed E	Зу	Da	ıte:	Signature of	of Surve	yor:				Date:	
Reviewed By Reviewed By Date: Signature of Surveyor: Date:  CMS RO  Followup to Survey Completed on: Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS 3567) Sout to the Facility?	State Agency	/	]	PS/KJ	09	0/02/20	14		27200				07/	18/2014
Followup to Survey Completed on:  Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS 3567) Sont to the Facility?	Reviewed By	,		•	Da	ite:	Signature of	of Surve	yor:				Date:	
Uncorrected Deficiencies (CMS 2567) Sout to the Facility?	CMS RO													
Uncorrected Deficiencies (CMS 2567) Sent to the Excility?	Followup to Survey Completed on:					Check	for any	Uncorrected	Defi	ciencies. Was	a Summary of	-		
		5/15/	/2014					-				-	YES	NO

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 5L8E

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I - TO BE CO	MPLETED BY T	HE STAT	E SURVE	YAGE	ENCY		Facility ID: 00109
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245465  2.STATE VENDOR OR MEDICAID NO.     (L2) 668340100	(L1) <b>245465</b> (L3) <b>COMMUNITY N</b> 2.STATE VENDOR OR MEDICAID NO. (L4) <b>410 WEST MAIN</b> (L2) <b>668340100</b> (L5) <b>OSAKIS, MN</b>				(L6)	56360	4. TYPE OF ACTION  1. Initial  3. Termination  5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/S	SUPPLIER CATEGORY 05 HHA	Y 09 ESRD	<u>02</u> 13 PTIP	(L7)	22 CLIA	7. On-Site Visit  8. Full Survey After	9. Other Complaint
0 Unaccredited 1 TJC	(L34) 02 SNF/NF/Dual (L10) 03 SNF/NF/Distinct 04 SNF	06 PRTF t 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSP			FISCAL YEAR ENDIN	G DATE: (L35)
2 AOA 3 Other  11. LTC PERIOD OF CERTIFICATION  From (a):	10.THE FACILIT	TY IS CERTIFIED AS:		And/Or	Approve	d Waivers Of The	Following Requirements:	
		Requirements ince Based On:  Acceptable POC		3 4	3. 24 Ho 1. 7-Day	cal Personnel ur RN RN (Rural SNF) afety Code	6. Scope of Ser 7. Medical Dire 8. Patient Roon 9. Beds/Room	ector
13. Total Certified Beds 50		ompliance with Program ements and/or Applied V		* Code:		3*	9. Beds/Room (L12)	
14. LTC CERTIFIED BED BREAKDOWN				15. FACILI	TY MEI	ETS		
18 SNF 18/19 SNF 50	19 SNF ICF	IID		1861 (e)	(1) or 18	361 (j) (1):	(L15)	
(L37) (L38)	(L39) (L42)	(L43)						
16. STATE SURVEY AGENCY REMARKS (IF APPL	ICABLE SHOW LTC CANCE	ELLATION DATE):						
See Attached Remarks								
17. SURVEYOR SIGNATURE	Date	e:		18. STATE	E SURVI	EY AGENCY APP	PROVAL	Date:
LoAnn DeGagne, HFE	NE II	06/03/2014	(L19)	Kate J	ohns	Ton, Enfo	rcement Special	ist 06/19/2014 <sub>(L20)</sub>
PART	II - TO BE COMPLET	TED BY HCFA RE	EGIONAL	OFFICE	OR SI	NGLE STAT	E AGENCY	
DETERMINATION OF ELIGIBILITY		OMPLIANCE WITH C IGHTS ACT:	IVIL	21.	2. Ov		al Solvency (HCFA-2572) nterest Disclosure Stmt (HC	FA-1513)
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE 23. LTC	AGREEMENT	24. LTC AGREEME	ENT	26. TERM	MINATIO	ON ACTION:		(L30)
OF PARTICIPATION BE 04/01/1987	GINNING DATE	ENDING DATE	E	01-Merger	, Closure		05-Fail to	Meet Health/Safety
(L24) (L4	· · · · · · · · · · · · · · · · · · ·	(L25)				W/ Reimbursemen ary Termination		Meet Agreement
	ERNATIVE SANCTIONS Suspension of Admissions:	(L44)				· Withdrawal	OTHER 07-Provid- 00-Active	er Status Change
(L27) B. F	Rescind Suspension Date:	(L45)						
28. TERMINATION DATE:	29. INTERMEDIARY	Y/CARRIER NO.		30. REMA	RKS			
(L28)	03001		(L31)	AW	K67	' Emailed	CMS 06/20/2	014 Co.
31. RO RECEIPT OF CMS-1539	32. DETERMINATIO	N OF APPROVAL DAT	ГЕ	Post	ed 0	6/20/2014	ł Co.	
(L32)			(L33)	DETER	MINAT	TON APPROV	VAL	

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00109

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

Page 2

Provider Number: 24-5465

Item 16 Continuation for CMS-1539

At the time of the extended survey completed 04/17/14, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required as evidenced by the attached CMS-2567. The facility's request for a continuing waiver involving the deficiency cited at K67 has been recommended. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5151

May 6, 2014

Mr. David Carlson, Administrator Community Memorial Home 410 West Main Street Osakis, Minnesota 56360

RE: Project Number S5465024 & F5465023

Dear Mr. Carlson:

On April 17, 2014, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not

immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 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.

#### REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on April 17, 2014, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

### **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:

Jessica Sellner, Unit Supervisor Minnesota Department of Health 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320)223-7365

Fax: (320)223-7365

### NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective May 11, 2014. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Per instance civil money penalty for the deficiency cited at F 223. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

### SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Community Memorial Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 17, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

### **APPEAL RIGHTS**

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter.

Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

### PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

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

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

### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

# 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 July 17, 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 October 17, 2014 (six months after the

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

### INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Community Memorial Home

May 6, 2014

Page 7

Kate Johnston, Program Specialist

Licensing and Certification Program

Division of Compliance Monitoring

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

PRINTED: 05/06/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245465	B. WING_	· · · · · · · · · · · · · · · · · · ·	04.	/17/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		FC	000			
	as your allegation of one Department's accepta	nce. Your signature at the ge of the CMS-2567 form will					
	Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.						
F 223 SS=K	Minnesota Department 15th, 16th and 17th, 2 an Immediate Jeopart facility's failure to ensome resistive with cares wore with cares wore with the high post pacific to the high post pacific to the high post pacific to the high post pacific with the lower scope, which was a completed on April 16 483.13(b), 483.13(c)(ABUSE/INVOLUNTAI). The resident has the sexual, physical, and punishment, and involves	1)(i) FREE FROM RY SECLUSION  right to be free from verbal, mental abuse, corporal luntary seclusion.  use verbal, mental, sexual, rporal punishment, or	F 2	accepted 311	Y W		
_ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPFUER REPRESENTATIVE'S SIGNATUR	E			(X6) DATE	

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED	
		245465	B. WING		04/17/2014
	ROVIDER OR SUPPLIER	<u> </u>	STF 410		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 223	by: Based on observat review, the facility facesidents, (R44, R5 exhibited combative physically abused w restrained by staff p. The failure of the fa residents were assed developed/monitore interventions were i implemented by sta and oversight of sta restraining resident cares, which resulte resulted in an imme R34, and R53. The staff as residents w and as a result staff  The immediate jeon 4:47 p.m. when the comprehensively a implement interven residents were not during the performa administrator and con ontified of the imme R50, R34, and R53 IJ was removed on noncompliance ren	ion, interview, and document ailed to ensure 4 of 4 0, R34, and R53) who e behaviors were not when the resident(s) were providing necessary cares. Cility to ensure combative eased, interventions and to ensure appropriate in place and were in place and were off, the lack of investigation aff who acknowledged in bruising to residents, ediate jeopardy for R44, R50, se residents were identified by the were combative with cares if restrained them.	F 223	F223 Plan of correction 5/16/14  Resident 44, 50, 34, and 53 were assessed for bruising 4/16/14 which was not correlated to any document incidents. No injuries were noted on residents 44 and Bruising, not correlated with incident was located on resident 50 and 34 which with with immediately filed to OHFC the facility administrator with updated.  All residents in the facility of discussed on 4/15/14 and 4/16/14 with both IDT and direct care staff and 4 other residents in the facility were determined to be at a high risk of obtaining injury related to their combative and aggressive behaviors. These other residents were also	on  ited  53. th an  vere after  vas  were  er re er ted
	R44's admission re	ecord identified diagnoses			

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/06/2014 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA
(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY
COMPLETED

NAME OF PROMPER OR SUPPLIER  COMMUNITY MEMORIAL HOME  DATE OF PROMPER OR SUPPLIER  COMMUNITY MEMORIAL HOME  SUMMANY STATEMENT OF DEPRICENCIES (EACH DEPRICENCY MUST BE PRECEDED BY FULL TAG  FEACH DEPRICENCY MUST BE PRECEDED BY FULL TAG  FOR CONTINUED FROM SOME USE DEPRICENCY TAG  CONTINUED FROM USES DEPRICENCY TAG  Continued From page 2 including dementia. The quarterly Minimum Data Set (MOB) dated 11/61/4, identified the resident had severe cognitive impairment, required extensive assistance with activities of daily living (ADLS), and rejected care 4-6 days of the 7 day look back assessment period. R44's Behavior Care Area Assessment (CAA) dated 57/21/14, identified resident Thas a diagnoses of dementia She does recognize her room, certain staff members, family. She has memory and judgment deficits. She is resistive to cares, and unpredictable in her reaction to staff when they are providing personal cares. Typically once the task is completed, she is pleasant and cooperative" However, the CAA filed to comprehensively assess R44's ongoing behaviors to ensure interventions were in place related to R44's behaviors to direct staff on how to provide cares to the resident to combative behaviors. LPNE-O staded it is "just easier" on R44 to quickly "get the cares done" because it was difficult to redirect the resident one she became agitated, to combative behavior, LPNE-O staded it is "just easier" on R44 to quickly "get the cares done" because it was difficult to redirect the resident one she became agitated, buring observation on 4/15/14, at 4.00 pm. R44 was observed quietly sitting in a wheelchair in the dayroom watching the birds. On 4/15/14, at 5.35 pm. R44 was in the dining room being assisted by a [unknown] nursing assistant (IAA) and was ooperative  The care plans of the affected residents 44, 50, 34 and 53 along with the 4 other residents which were determined to be at risk had their care plans trick the resident form to the advertible of the staff to home to be a staff to change the resident staff to t		CORRECTION	IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	COM	PLETED
COMMUNITY MEMORIAL HOME    VAI D   SUMMARY STATEMENT OF DEFICIENCIES   PROPERTY   PROPER			245465	B. WING			04	/17/2014
FEETX TAG  FREGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG  FREGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG  FREGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG  Continued From page 2 including dementia. The quarterly Minimum Data Set (MDS) dated 1/16/14, identified the resident had severe cognitive impairment, required extensive assistance with activities of daily living (ADLs), and rejected care 4-6 days of the 7 day look back assessment period. R44's Behavior Care Area Assessment (CAA) dated Si/21/14, identified resident "has a diagnoses of dementia. She does recognize her room, certain staff members, family. She has memory and judgement deficits. She is resistive to cares, and unpredictable in her reaction to staff when they are providing personal cares. Typically once the task is completed, she is pleasant and coperative" However, the CAA falled to comprishensively assess R44's ongoing behaviors to ensure interventions were in place related to R44's behaviors to direct staff on how to provide cares to the resident.  During interview on 4/15/14, at 8.50 a.m. licensed practical nurse (LPN)-C reported R44 can be a "difficult" resident for staff to provide cares to the resident. 2 staff to change the resident's brief (incontinence product) and one staff to hold R44's hands down. LPN-C stated it is "just easier" brief (incontinence product) and one staff to hold R44's hands down. LPN-C stated it is "just easier" brief (incontinence product) and one staff to hold R44's hands down. LPN-C stated it is "just easier" brief (incontinence product) and one staff to hold R44's hands down. LPN-C stated it is "just easier" on R44 to quickly "get the cares done" because it was difficult to redirect the resident once she became agitated.  During observation on 4/15/14, at 4:00 p.m. R44 was observed quietly sitting in a wheelchair in the dayroom watching the birds. On 4/15/14, at 6:30 a.m. licensed practical luring the provide cares to the resident in the dayroom watching the birds. On 4/15/14, at 6:30 a.m.			:	•	410	WEST MAIN STREET		
F 223 Continued From page 2 including dementia. The quarterly Minimum Data Set (MDS) dated 1/16/14, identified the resident had severe cognitive impairment, required extensive assistance with activities of daily living (ADLs), and rejected care 4-6 days of the 7 day look back assessment period. R44's Behavior Care Area Assessment (CAA) dated 5/21/14, identified resident "has a diagnoses of dementia. She does recognize her room, certain staff members, family. She has memory and judgement deficits. She is resistive to cares, and unpredictable in her reaction to staff when they are providing personal cares. Typically once the task is completed, she is pleasant and cooperative" However, the CAA failed to comprehensively assess R44's ongoing behaviors to ensure interventions were in place related to R44's behaviors to direct staff on how to provide cares to the resident.  During interview on 4/15/14, at 8:50 a.m. licensed practical nurse (LPN)-C reported R44 can be a "difficult" resident for staff to provide cares to the resident, 2 staff to provide cares to the resident to combative behavior.  During interview on 4/15/14, at 8:50 a.m. licensed practical nurse (LPN)-C reported R44 can be a "difficult" resident for staff to provide cares to the resident.  During interview on 4/15/14, at 8:50 a.m. licensed practical nurse (LPN)-C stated it is "just easier" on R44 to quickly "get the cares done" because it was difficult to redirect the res	PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
R44's care plan, last updated on 1/24/14,	F 223	including dementia Set (MDS) dated 1. had severe cognitive extensive assistant (ADLs), and rejected look back assessmidentified resident. She does recognized members, family. Sudgement deficits. Unpredictable in hear providing personal task is completed, cooperative How comprehensively a behaviors to ensure related to R44's beto provide cares to During interview or practical nurse (LP "difficult" resident for the combative behaviors to ensure task in the combative behaviors to ensure the product of the combative behaviors to ensure the combative behaviors to ensure the product of the combative behaviors to ensure the combative behaviors to ensure the combative behavior to staff to combative behaviors and one supported the cares donored the care t	The quarterly Minimum Data //16/14, identified the resident ve impairment, required be with activities of daily living ad care 4-6 days of the 7 day ment period. R44's Behavior ment (CAA) dated 5/21/14, thas a diagnoses of dementia. The hear room, certain staff she has memory and she is resistive to cares, and the reaction to staff when they conal cares. Typically once the she is pleasant and wever, the CAA failed to ssess R44's ongoing the interventions were in place thaviors to direct staff on how the resident.  In 4/15/14, at 8:50 a.m. licensed with the provide cares to the resident, the resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to hold R44's hands down. The resident's brief (incontinence thatf to h	F	223	which were not documented an incident report. No new of unexplained injuries were noted.  The care plans of the affecteresidents 44, 50, 34 and 53 along with the 4 other reside which were determined to brisk had their care plans reviewed and updated on 4/16/14 to include a more focused "behavior plan". This plan has resident specific interventions for the direct of staff to use when/if the resident displays aggressive behaviors.  Skin audits were started the week of 4/21/14 for the 8 residents above which will occur 3 times a week for 60 days. The remaining resident in the facility will have week skin audits done starting the	d ents e at	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		245465	B. WING		04/17/2014
	ROVIDER OR SUPPLIER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 110 WEST MAIN STREET DSAKIS, MN 56360	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 223	identified the resident included her restivent could become physics. She also had a history during personal care staff, "when doing may work better if or and engages her with words/ conversation.  On 4/14/14, the facility reports from January The DON reported a January 1, 2014 had therefore not available. An injury report date "was combative with noted to have grabbed my write of her hand was bleen an abrasion to the tocleansed, 3 steri string and wrapped with clipinvestigation was for evidence of further a interventions being in the control of the	t had behaviors, which ess with personal cares and cally and verbally aggressive. ry of striking out at staff s. The interventions directed cares, check/ change in bed; the person holds her hands the explanations/ soothing to distract from the cares"  Ity provided R44's injury of 1, 2014, to present time. Ill injury reports prior to been shredded and le.  Ith HS [hour of sleep] cares the distaffs wrist. Staff stated, the HS [hour of sleep] cares the distaffs wrist. Staff stated, the mer grasp and looked the top the ding noted resident to have the pof her right hand' wound	F 223	being monitored for unkninjuries. In addition to skin audits, the 8 residents about which were determined to risk for injury are being autwice weekly during ADL to monitor the direct care and resident interaction was are being provided. ADL care audits will contituice weekly for 30 days 4/21/14 and then weekly the following 30 days. And bruising or injury found was followed up on and invest by licensed staff to assure the resident is free from.  The Accident/Injury policy procedure will be followed a vulnerable adult will be submitted if the injury is fan unknown cause or abu	nove o be at udited cares e staff while These nue from for y vill be tigated e that abuse.  v and d and

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION		TE SURVEY MPLETED
		245465	B. WING_				4/17/2014
	ROVIDER OR SUPPLIER			410	EET ADDRESS, CITY, STATE, ZIP CODE WEST MAIN STREET AKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	An injury report dated "had incontinent BN was combative with A hitting out at staff. St hands to prevent her striking out at staff. A Resident was unawar monitoring form dated left wrist bruising whice (centimeter) x 5.2 cm which measured 3.6 assessment indicated being used were, "Trresident when combainvestigation/intervent An injury report for RWhen NA [nursing resident with her A.M to have 2 bruises to be observed bruises to be measuring 6 cm x 3 c [night] nurse reported combative during car hands and arms. Is I residents combativer investigation was four evidence of further a interventions being in A review of R44's propresent was completed: 9/11/13- "Resident his forearm. NA noticed Inside of residents ledried blood as well."	I 3/2/14, indicated R44, I [bowel movement] and IM [morning] cares. Was aff was holding onto her from digging into BM and at lunch bruises were noted. The image is a second of the image is a secon	F:	223	As of 5/16/14, all nursing standard been assigned two education sessions called "Abuse Prevention In Persowith Dementia: The Basics" "Client Behaviors: Assessment and Intervention in the Resident with Dementia" from the online education system "Healthcare Academy". The staff have until June 6th, 20 to complete the required education courses until discipline is enforced by administration.  The following system change have taken place since 4/10. A new facility investigative was developed and implemented which including the incident, interview of staff involved, care plan interventions. All members of the IDT review sign off on the incident including the facility	ns and ent om n, 14 ses 5/14- form es a and	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED	
		245465	B. WING		04/17/2014
	PROVIDER OR SUPPLIER		410	REET ADDRESS, CITY, STATE, ZIP CODE WEST MAIN STREET AKIS, MN 56360	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 223	old dried blood. On I abrasion contains a be Resident unable to de abrasion measuring approximately 5 cm on further investigation injury found in the met 10/3/13- "Occasional behavior are effective home staff as per PC 10/8/13- "RN manage behaviors during PM 11/5/13- " is still intecare, most at HS." 11/25/13- " combation unusual" 12/25/13- " has be resistive this shift" 1/5/14- " Resident staff with peri cares to 1/10/14- " Resident cares" 2/19/14- " was cores scratching a staff med 3/3/14- " staff report behaviors. Both fore states she doesn't red 3/7/14- " Combative verbal with HS round minimal success." 3/10/14 "resident pinched NA during be Resident is usually rechanges during the red 1/10/14 in the resident is usually rechanges during the red 1/10/14 in the resident is usually rechanges during the red 1/10/14 in the resident is usually rechanges during the red 1/10/14 in the resident is usually rechanges during the red 1/10/14 in the resident is usually rechanges during the red 1/10/14 in the red 1/1	ateral side of arm near blue/ dark purple hematoma. escribe what happened 4.5 cm x 0.8 cm. Hematoma (3 cm x 1 cm." There was on or explanation of this edical record. episodes of combative ely managed by nursing (C (plan of care)." er reports some combative cares" ermittently combative with we with HS cares but nothing embative with cares. Assist of and assist into bed" even very combative and was hitting and pinching his AM." was combative with HS eagain this afternoon, ember's wrist. "tincreased hitting out earms badly bruised. She member how it happened." with 10:00 p.m. rounds, is. Redirected behavior with did become combative and rief change during the night. esistive/combative with brief hight shift"	F 223	administrator Monday thro Friday and daily by an RN. T administrator is notified immediately of any inciden which are VA reportable per Vulnerable Adult Policy and Procedure on all days of the week including weekends. If Incident/Accident Policy and Procedure was updated to include these revisions. The Mood/Behavior Policy and Procedure was also update the DON on 4/16/14 to include the addition of individualize "behavior plans" which will put into place if a resident risk of injury related to aggressive behaviors. These resident specific behavior is will be reviewed with resident and their families during scheduled care conferences assure that all intervention place are beneficial, appropriate and agreed up by both staff and	ts ts tr II e On d d by lude ed I be is at e blans ents s to s in

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING_			04	1/17/2014
	ROVIDER OR SUPPLIER			410	REET ADDRESS, CITY, STATE, ZIP CODE WEST MAIN STREET AKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 223	3/13/14- "noted to be verbal outbursts during nigl 3/14/14- "combative during HS cares" 3/16/14- "Combatic combative hitting, scrattempting to bite at smidnight, 2:00 a.m., a 3/19/14- "Combative assisting her with HS cooperative with auth the room and finished cares" 4/3/14- "There has improvement with he [in anti-psychotic med be combative with monot redirect able with may be helpful, at time Although R44's progresident was consisted while providing cares resident receiving bruto provide any invest assessments comple combative behaviors used to ensure intervand being implement During an interview of reported R44 was coproviding cares. NA-take 3 staff to change resident was "smalle with 2 staff; one staff brief and one to hold the resident from hitt also reported that if Fallow in the staff proported that if Fallow in the staff proporte	pe combative and have and HS cares. Was also at every 2 hour rounds."  Ive and have verbal outbursts atching, pinching and staff during 10:00 p.m., and 4:00 a.m. cares"  It and agitated with NA cares. Was compliant and or. Author excused NA from a dassisting resident with HS as been no significant obst personal cares, and is this. Change in caregiver lies not."  eas notes identified the ently combative with staff which resulted in the uising, the facility was unable ligation, tracking, or any ted regarding R44's or staff interventions being entions were appropriate ed.  In 4/15/14, at 9:05 a.m. NA-A	F	223	residents/families. On 4/1 the DON, Administrator at LSW reviewed the facility Vulnerable Adult Policy ar Procedure and made multichanges which include the addition of reference chesuspension for employees under investigation by DH training of new employees a focus on Alzheimer's/dementia carstaff burnout, and supportare of the residents duritipending investigation of a incident. On 4/17/14 the contacted all licensed statinformed them of the chain the Vulnerable Adult Pland Procedure and the revisions made to the Incident/Accident Policy at Procedure. A mandatory nursing staff meeting was on 4/24/14 and a review revised incident/accident procedure was reviewed. staff are aware that all incident and the revisions made to the procedure was reviewed.	nd ciple cks, scs, s with re, tive ng nn DON ff and inges colicy and cheld of the	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED
		245465	B. WING				04/17/2014
	ROVIDER OR SUPPLIER			ST 41 O:			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223	and get it over with." During an interview o NA-D indicated R44 when they are providi resident). NA-D repo staff assist with cares required to help so or resident's hands dow done." NA-D stated bruising to R44's wris holding them down w personal cares done, resistive and staff are residents cares done NA-D indicated she fe had developed bruisi to perform cares, but so fragile and struggl we are holding them. month ago R44 need and was resistive. Na the resident's wrists/ be cleaned up. NA-D later staff observed R "like perfect hand prin her feel "horrible."  R50's admission MD: diagnoses that includ dysthymic disorder at ischemic attacks (TIA impairment, required ADL's, and rejected of back assessment per 2/18/14, identified res has progressed to wh nonverbal, depender is unable to express	n 4/15/14, at 9:35 a.m. was combative with staff ing cares to her (the rted R44 only required one , but usually 2 staff were he staff can "hold the n when cares are being she knew staff had caused tts, arms, and ankles from hen staff were trying to get but "the residents" are so i just trying to get the as quickly as possible. elt "horrible" when residents hig from holding them down she stated, "They are just ing with us so much when " NA-D stated about a ed to have her brief changed A-D stated staff had to hold hands so the resident could o reported about 2-3 hours t44's wrists were bruised hts." NA-D stated that made	F	223	investigated to find root cause and to assure that the investigation component is complete. All staff are aware that they are mandated reporters. If abuse has been suspected, a Vulnerable Adul report will be submitted immediately.  Risk meetings will be held monthly starting in May 201 and will have a focus on reviewing incidents/accident and individual resident care plans to address behavior pland interventions. This mee will continue indefinitely. An noted trends will be thorough reviewed by the team and brought forth and discussed during the facility's QA&A meetings.  The corrective action for F2 was completed on 5/16/14	t 4, ans ting ny ghly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245465	B. WING_			4/17/2014	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 223	does so aimlessly abortombative with cares, others near her- espeshe is going. This purself or others." Howe comprehensively assubehaviors and to ensuplace related to R50's how to provide cares  R50's care plan updaresident was resistive verbal and physical remay reach out and grapath. The intervention thought process where warm during cares, and music or items to mare During observed in the kanother resident (R34 repeatedly said, "Stop With no communication staff member grabbed wheelchair and pulled bird room into the hall sitting in the hallway at On 4/14/14, the facilit R50's injury reports from the prosent. The DON in reports/ investigations. A review of a Wound form, dated 4/3/14, indifferearm bruising mea	pel her wheelchair, and but the facility. She is and may act out towards cially if in the path of where its her at risk for injury for ver, the CAA failed to less R50's ongoing are interventions were in the behaviors to direct staff on to the resident.  Ited 4/14/14, identified the less with cares, wandered, esistance with cares, and ab at other people in her instructed allow time for in providing cares, keep her and attempt to distract with inipulate her hands.  In 4/15/14, at 6:30 p.m. R50 bird room and was pinching to in the upper left arm. R34 by get the hell out of here!"  In the back of R50's the heack of R50's the backwards out of the laway. The resident was left alone.  In years asked to provide om January 1, 2014 to dicated R50 had no injury to during that time period.  Assessment/ Monitoring	F2	223			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING			4/17/2014
	ROVIDER OR SUPPLIER	E		STREET ADDRESS, CITY, STATE, : 410 WEST MAIN STREET OSAKIS, MN 56360	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIATE DIENCY)	(X5) COMPLETION DATE
F 223	of unknown origin care plan revisions Review of R50's p following:  2/12/14- "Not alert communicate need not able to redirect 2/13/14- "Combative"  2/13/14- "In AM streem and able to redirect 2/13/14- "In AM streem bative"  2/15/14- "NAs not with HS cares."  2/16/14- "NAs not with HS cares."  2/16/14- "Residen with AM cares; wow When up has bee wheelchair and ru walls continuously 2/17/14- "Hit at streem and ru walls continuously 2/17/1	ras found regarding the bruise or any further assessment/s.  rogress notes identified the  cor orientated x 3 or able to dsCombative with HS cares, t."  ve with HS cares."  ne was noted to be verbal and dist with cares due to being  ed resident to be combative  t very combative this morning ould hit out and pull staffs hair. In scooting around facility in ins into other residents and	F	223	JENCY)	
	pinching, and squ 2/18/14- "During A be combative tow	ive throughout shift, hitting, eezing arms of personnel."  AM cares resident was noted to ards NA. NA explained each uring, this did improve				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING			04/17/2014	
	ROVIDER OR SUPPLIER  ITY MEMORIAL HOME		410	EET ADDRESS, CITY, STATE, ZIP CODE WEST MAIN STREET AKIS, MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 223	cares has been wher wheelchair into objects."  2/22/14- "Combative 2/24/14- "Wheeling wheelchair in bird reduring HS cares. Relothes, wash cloth, 2/25/14- "Running i wheelchairs and als residents rooms Also combative whirounds during the n 2/26/14- "Combative night."  2/27/14- "Found in also running into ot NAs noted resident HS cares."  3/2/14- "Combative wandering into othe Redirected with sor 3/3/14- "Resident whough the facility Was found multiple rooms, digging in dalso noted multiple residents' wheelchairs wheelchair	ative and verbal with AM andering in halls and running residents, staff, and other with AM cares."  into other resident's food hitting out at staff esistive with cares, grabbing towel and bedding."  Into other resident's food wandering into other combative during HS cares. The being repositioned on light."  We with reposition during the combative during the com	F 223				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B, WING_			04/1	17/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 223	Staff attempted redired during PM shift- all at very combative during 3/4/14- "Noted to be other resident rooms. Noted to be hitting out Resistive Staff explishe continued to be rotal assist of 2"  3/5/14- "Wanders into Does not leave other being yelled at by that were made by staff to combative and resisticares."  3/14/14- "Has been notares in AM."  3/15/14- "Grabbed ar Staff assistance requiparts of the assistance requiparts of the area of the assistance of the assistance requiparts of the assistance of	ecting resident multiple times tempts failed. Noted to be g HS cares."  wandering in and out of Combative with HS cares. t at staff during HS cares. ained procedure to her, and esistive and combative.  o other resident's rooms. residents' rooms even if t resident. Several attempts oredirect, without success we with staff during HS  oted to be combative with  nother resident in the chest. ired to get her to let go."  red by staff that she had dent in the chest. her resident. Author as about to run another th her wheelchair. ares."  ombative with her personal ghout the building in her	F 2				
FORM CMS-256	7(02-99) Previous Versions Obs	iolete Event ID: 5L8E11		Facility ID: 00109	If continu	ration sheet	t Page 12 of 84

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245465	B. WING_		04/	17/2014		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
F 223	Although the review of medical record indicated documentation of R50 cares, there was no for assessment of the ensure appropriate in During interview on 4 stated R50 is combatis attempting to provishe stated when proving the stated when proving the stated when proving the stated when proving the stated when proving to the hold the resident's be provided. NA-A substantially behavior to the nurse not know what the nuas the resident's combinative and the resident's combinative and the resident's combinative and the resident's tried to talking with her, but Find NA-D stated sometime the residents brief behaviors and strong." She was against the wall R50's head to hold held two staff get the residents done or we wo stated she reports the time" but nothing is error as the residents. NA-	of the progress notes in R50 ted consistent ongoing D's restiveness with personal purther investigation, tracking, se combative behaviors to terventions are in place.  1/15/14, at 9:05 a.m. NA-A ive "all the time" when staff de cares to the resident.	F 2	23				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING_		04	/17/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)		BE	(X5) COMPLETION DATE	
F 223	R34's quarterly MDS resident had diagnose vascular disease, der She had moderate co extensive assistance care 1-3 days of the 7 period. R34's CAA daresident, "Has diagno behaviors. She is ale recognizes staff, facili unaware of time of da quick to have mood cangry and reverse. Sideficit with hearing air wear (similarly her glasher interpretation of hisolation, misunderstate CAA failed to compreongoing behavior to estate the compression of the com	dated 2/13/14, identified the es that included peripheral mentia and anxiety disorder. Ignitive impairment, required with ADLs, and rejected 7 day look back assessment ated 11/21/13 identified the esis of dementia with est, orientated to self, ity locations. She is ay, month. She is easily/hanges from pleasant to the does have a hearing ds which she refuses to asses's) which could impact er surroundings. At risk for andings." However, the hensively assess R34's ensure interventions were in a behaviors to direct staff on	F	223			
	resident is verbally ag cares. Staff were instaffierent staff if reside report to nurse cause when behavior is exh communication was nunderstands what wa for behavior with residuals, safe, staff were direct behavior stops. They and "verbally demand During an observation R34 was seated in he	naintained and resident s happening, and set limits dent. If non-compliant and led to leave situation until were to reapproach later					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i i	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245465	B. WING_		,	04/17/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHO		(X5) COMPLETION DATE	
F 223	R34 kept saying, "Std A [unknown] staff me R50's wheelchair and the bird room into the sitting in the bird roor by staff to ask the resishe had any injuries.  On 4/14/14, the facilitize and the DON reported allow January 1, 2014, had therefore not available.  An injury report date to have bruising to bill had increased physic cares, including hittin with fists, bare hands transfers. The immediate many identification of when angry further investigation of any identification of whe for the resident.  Review of R34's Would identified the following the forearm bruising [depth]. The monitoribruising was dark pur assessment or investibruising.	ing her in the upper left arm.  Inp., get the hell out of here!" Imber grabbed the back of a pulled her backwards out of a hallway. R34 was left in and was not approached ident what happened or if  It provided R44's injury 1, 2014, to present time. I injury reports prior to been shredded and e.  Ind 1/20/14, indicated, "Noted ateral arms and wrists, has all behaviors with staff during g at staff and hitting PAL lift typically during cares and diate action taken was, I healed. Leave and rewith cares." There was no of this incident nor was there which staff had been caring and Assessment Monitoring g:  Ind Assessment Monitoring g:	F2	223			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING_			04	/17/2014
	ROVIDER OR SUPPLIER  ITY MEMORIAL HOME			410 \	EET ADDRESS, CITY, STATE, ZIP CODE WEST MAIN STREET KKIS, MN 56360	•	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI: TAG	REFIX (EACH CORRECTIVE ACTION SHOUL		3E	(X5) COMPLETION DATE
F 223	appearance indicate multiple to left arm. in color. Discontinue Resident may be but 1/11/14- Right forear around the edges of fading in the middle. bruise." There was rexplanation of the bruising. "Has one put the left hand and has her forearm." There or explanation of the Review of R34's profollowing:  12/23/13- "Had one physical behaviors of 1/4/14- "Was rude at AM. She grabbed on being assisted to the 1/15/14- "Resident in combative with staff and scratching staff inappropriate in Resistive with transfer 1/17/14- "noted to staff. Was noted to treaching out, and put 1/11/14- "noted to staff. Was noted to treaching out, and put 1/11/14- "noted to staff. Was noted to treaching out, and put 1/11/14- "noted to staff. Was noted to treaching out, and put 1/11/14- "noted to staff. Was noted to treaching out, and put 1/11/14- "noted to staff. Was noted to treaching out, and put 1/11/14- "noted to staff. Was noted to treaching out, and put 1/11/14- "noted to staff. Was noted to the contraction of the multiple staff. Was noted to the contraction of the multiple staff. Was noted to the contraction of the multiple staff. Was noted to the contraction of the multiple staff.	d, "Bruising to hand and Bruises are dark blue/ purple emobility bars in bed. mping her arms on these."  Implies bruising. "Dark purple bruising. Appears to be Yellow color to middle of no further investigation or uising.  In and bruising and left arm being sized bruise present on a multiple bruises present on was no further investigation bruising.  In gress notes revealed the bruief episode of verbal and uring AM cares."  In d combative with cares this he of the staff's hair when the bathroom."  Oted to be very verbal and this shift. Hitting, kicking, during HS cares. Also calling ames and swearing at them. Be be hollering out/swearing at the such ing at staff, as well as with multiple bruises to	F	223			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	·	245465	B, WING_			0	4/17/2014
	ROVIDER OR SUPPLIER						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIED CONTROL OF THE A		(X5) COMPLETION DATE
F 223	physical with staff throhitting with HS cares hour rounds."  1/25/14- " was verbated AM cares"  2/4/14- " very resist this shift. Both HS cares was noted to be hitting."  2/6/14- Resident "vertishift. Yelling 'bitch; you Combative with HS cares	orbited to both verbal and bughout shift was also and during [night] every 2 all and combative with her live and physical with cares ares and [night] rounds. If all and combative at start of our stupid; just go to hell. If ares."  Interest of the verbal and ares Also hit at staff while aring [night] every 2 hour combative with HS cares. While being repositioned hour rounds."  Interest of the residents and staff is also combative during he night"  It into this AM resident assessment or investigation	F	223			
		ently combative with staff					

CLIVILIV	STOR MEDICARE &	VIEDIONID SERVICES	- T		CIVID NO.	. 0000-0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE S COMPL	
		245465	B, WING	·········	04/1	7/2014
	ROVIDER OR SUPPLIER  TY MEMORIAL HOME		4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET SAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 223	to provide any investig assessments related behaviors or staff interensure interventions wimplemented.  During interview on 44 reported R34 was constated staff would son the resident later to precious the cares. LFR34's arms and legs of get cares done on the During interview on 44 stated R34 is often constated it will often take cares because one has the other staff is proving R34 is very combative because she doesn't in the behavioral disturbance hyperplasia, cerebrow depression and psychiatric disturbance. The resident diagnoses the behavioral disturbance. The resident parament, required ADLs, and rejected callook back assessment 1/9/14, identified the redementia, complicate paramoia. He is awar	ising, the facility was unable gation, tracking, or to R34's combative rventions being used to were appropriate and being where a staff to assist entered as an extra staff to assist ents arms and legs to PN-C indicated often holding down was the only way to excident.  In 15/14, at 9:05 a.m. NA-A ambative with cares. NA-A et a few of us to provide as to "hold her hands" while ding the cares. NA-A stated to when males provide cares like men to take care of her.  In 15/14, identified at included dementia with expension prostatic asscular accident, nophysical visual dent had moderate cognitive extensive assistance with are 1-3 days of the 7 day at period. R53's CAA dated resident, "Has diagnosis of divith history hallucinations, eof his location, recognizes	F 223			
	family, his judgement	and reasoning are				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING		C	4/17/2014	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360			
(X4) ID PREFIX TAG	. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 223	Continued From page 18 impaired. He does not recognize his own limitations, potential hazards, or social restraints. His cognition losses have become more apparent in the past year" However, the CAA failed to comprehensively assess R53's ongoing behaviors to ensure interventions were in place related to R53's behaviors to direct staff on how to provide cares to the resident related to his hallucinations or paranoia.  R53's plan of care dated 4/14/14, identified the resident hollered and yelled and indicated if "painful [did not identify what painful referred to], wants attention, or for no reasonnot always redirectable" The interventions directed the staff to ask the resident why he is yelling. He was also an assist of one staff for personal cares but if not cooperative, 2 staff were to be used.  During observation on 4/15/14, at 6:45 p.m. R53 was observed in the hallway outside of the dining room. The resident had his arms spread out with one hand on the wall and the other hand on the medication cart blocking the hallway. Several resident's were lined up behind him waiting to get by him down the hall. An [unknown] staff asked the resident to put his arms down so other resident's could get through. R53 did not respond to the staff or move his arms, so the staff member took the resident's arm and physically moved it, and pushed R53 into the dayroom.  During interview on 4/15/14 at 9:05 a.m. NA-A stated R53 was often combative with cares. NA-A stated she does not work with R53 often, but when she has, extra staff had to hold the residents arms down to allow staff to provide cares.		F	223			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245465	B. WING		04/1	7/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 223	Continued From page	19	F 22	3			
		provided R53's injury 1, 2014, to present. The orts prior to January 1, 2014					
	dated 3/2/14, with a re which identified the re HS cares, to thrashing noted to left arm after Checked PAL and bed Wound Assessment a identified R53 had (2) abrasion(s) measuring x 0.3 cm. The interve for any sharp edges."	nd Monitoring Report left antecubital (forearm) g 1.3 cm x 0.7 cm and 1 cm ntions listed were, "Check					
	present identified the 1/14/14- "Resident no	following: ted to be hitting another f the head today, NA quickly oom and told hìm this					
	resistive, paranoid, ye refuse cares, be irrital	ole but there is the im distracted or talked into					
	other residents. Staff hollering out for help. TV room, resident wa back of the other resident preventing her from leading to the staff of the other residents.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245465	B, WING		c	4/17/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 410 WEST MAIN STREET OSAKIS, MN 56360	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 223	go of the wheelchair reposition resident he hollering. Also was n pulled female NA's ha redirectable or able to 3/5/14- "Was resistive 3/20/14- "Noted to be during HS cares." Th note regarding the rescares.  Although R53's progresident was combaticares which resulted bruising, the facility winvestigation, tracking R53's combative behavior appropriate.  During interview on 4 stated R53 was combabout anytime you try NA-D also reported to him," but if he was co away and reapproach staff comes back and staff would need to relegs] to do cares. NA have to do" to complete During interview on 4 stated if a resident was would ensure the bruiensure healing. LPN-	When staff attempted to became resistive and oted to be combative and air. Resident was not be distracted."  with HS cares."  combative and resistive is was the last documented sident being resistive with east notes identified the we with staff while providing in the resident receiving as unable to provide any in or assessment related to aviors or staff interventions interventions were  15/14, at 9:35 a.m. NA-D relative with cares and "just to do something with him." wo staff can usually "handle mbative staff try to walk him later. NA-D indicated if R53 was still combative, strain him [hold his hands/-D stated, "We do what we ste cares.  15/14, at 8:50 a.m. LPN-C as noted with bruising she sing was monitored to C stated she was aware ombative residents down to	. F:	223		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245465	B, WING		04	/17/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 223	stated she did not thir investigation or report the bruising was relat combative while staff with cares. LPN-C st report is not always fi especially if it was known came from.  During interview on 4, stated she was aware combative residents to DON stated if a resideresistive with cares st safe, and reapproach have to get done for the are just some resident at the resident mand staff needs to get possible for these resident mand staff needs to get possible for these resident mand staff needs to get possible for these resident mand staff to provide the nest staff were restraining safety to make sure the striking staff or injuring injury reports of bruis times for some resident with cares." She stat suspicious and did not because the facility we came from and knew	straining residents. LPN-C not the bruising required sing because she was aware led to the resident being was assisting the resident lated an injury/ incident lated an injury/ incident lated out for bruising, bown where the bruising lated to the resident lated an injury/ incident lated and injury/ incident lated and incident lated and incident lated lated and incident lated l	F 2			
	behaviors or who wer	re combative with cares to interventions were in place;				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	FIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245465	B. WING			04/17/2014		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 410 WEST MAIN STREET OSAKIS, MN 56360	<del></del>			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE		
F 223	tracking of staff who were sidents when they wand received bruises. Considered the reside she felt the staff were the difficult residents.  During interview on 4. administrator stated here were receiving bruising restraining them to pradministrator stated if abuse occurring in the him immediately.  During interview on 4. worker (SW)-A stated bruising that was occurring in the day with herself, RN case residents with "bad be specific bruising or s	vere providing cares to the vere combative with cares DON stated she never nts were being abused as doing their best to care for vere was not aware residents in from the staff holding and ovide cares. The staff restraining and she was not aware of the curring from staff restraining and the DON, shavior! were discussed, but ecific behaviors were not stated she would just at had combative behaviors erformed bruising happened thin skin would bruise."  Id not suspect "our staff" of the past the bruising was were residents who were monitored and assessed to terventions were in place. Initially have a problem essing residents who are staff that needs to be better."	F	223				

STATEMENT OF DEFICIEN AND PLAN OF CORRECTI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245465	B. WING _		,	04/17/2014	
NAME OF PROVIDER OF				STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360			
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
bruising forward  The IJ was was remarked for the instruction of the i	she stated shars that beganoved on 4/17 ompleted the were trained is who are contructed it is not all behavior as R50, R34, are shown to prove the share shown to assess in the specific shown to assess in ful.  In off on them is the share shown to assess in ful.  In off on them is the share shown to assess in ful.  In off on them is the share shown to assess in ful.  In off on them is the share share shown to assess in ful.  In off on them is the share share shown that is the share	with cares, but going the "needs" to be involved.  In on 4/15/14, at 4:47 p.m. 1/13, at 4:20 p.m. when the following interventions:  In how to deal with Inhabitive during cares and ever acceptable to hold a ride cares. It is essessments were completed and R53 and staff were to approaches for those  all to identify any other all to be abusive with staff  Invere updated and staff was unicate with nursing to terventions which are  In the DON, SW-A, and RN eview all incident reports to ensure all incidents are the Incident/ Accident policy 1/14, to include, "An attempt use of incident will be made story of resident's behavior use to those behaviors for  work audits will begin on es are being performed as s with behaviors.  oversee the correction plan	F 2	23			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[ ' '		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245465	B, WING			04/	17/2014
	ROVIDER OR SUPPLIER			410 V	ET ADDRESS, CITY, STATE, ZIP CODE VEST MAIN STREET KIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 223 F 225 SS=E	pattern with no actual 483.13(c)(1)(ii)-(iii), (c) INVESTIGATE/REPC ALLEGATIONS/INDIVING The facility must not been found guilty of a mistreating residents had a finding entered registry concerning all of residents or misappand report any knowle court of law against a indicate unfitness for other facility staff to the or licensing authoritie.  The facility must ensuinvolving mistreatmer including injuries of unisappropriation of reimmediately to the add to other officials in acthrough established pattern turber further potentinvestigation is in proof the results of all investigation agency) incident, and if the all incident, and if the all incident, and if the all	harm but potential for harm.  (2)(2) - (4) (3)(2) - (4) (4)(3)(3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4		223	F225 Plan of correction 5/16/14  Resident 44, 50, 34, and 53 were assessed for bruising 4/16/14 which was not correlated to any documen incidents. No injuries were noted on residents 44 and Bruising, not correlated will incident was located on resident 50 and 34 which will immediately filed to OHFC the facility administrator will updated.	on ted 53. :h an vere after	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ONSTRUCTION		SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	1 ' '			COMP	PLETED
		245465	B. WING			04	/17/2014
NAME OF P	ROVIDER OR SUPPLIER	240400			EET ADDRESS, CITY, STATE, ZIP CODE		<u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>
				410	WEST MAIN STREET		
COMMUN	ITY MEMORIAL HOME			osa	AKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 225	Continued From page	e 25	F	225	Resident 16 had skin audit		
					performed on 4/26/14 whic	h	
					did not reveal any alteration	s in	
This REQUIREMENT is not met as evidenced by:  Based on interview and document review, the		「 is not met as evidenced			skin integrity or new injury.		
				Resident #16 is alert and wa	S		
	facility failed to ensure 5 of 5 residents (R44,			-	interviewed by the DON sho		
		R16) who experienced origin, potential staff abuse,			after incident on 3/11/14 pr		
	and/ or injury resultin			to her transport to hospital.			
	were thoroughly inve			Resident had denied staff			
	, -	dministrator and state the facility failed to ensure 1			abuse, but moving forward,	2	
	of 1 nursing assistan				vulnerable adult will be filed		
	disqualified to provide	e cares to residents without					
	direct supervision wa while providing care	is supervised and monitored			any fracture which is obtain	ea	
	Write providing care	to residents.			during cares.		
	Findings include:				All residents in the facility w	ere.	
	The facility Vulnerabl	le Adult Policy and			discussed on 4/15/14 and		
	Procedure/ Prevention	on Plan dated 2/3/12,					
		nknown Source: An injury			4/16/14 with both IDT and		
		as an injury of unknown the following conditions are			direct care staff and 4 other		
	met:				residents in the facility were		
		e injury was not observed by			determined to be at a highe		
	any person or the solution be explained by the r	urce of the injury could not resident and			risk of obtaining injury relat	ed	
	2.) The injury is sus	picious because of the extent			to their combative and		
	of the injury or the lo	cation of the injuryor the			aggressive behaviors. These	<u>4</u>	
		oserved at one particular ent of injuries over time			other residents were also		
	Incident reports are r	required for bruises, skin			assessed on 4/16/14 for inj	uries	
	tears, etc., of unknow	vn origin. The DON [director			which were not documente		
	of nursing]/ case mai	nager will look for possible ng while also watching for			an incident report. No new		
	patterns, occurrence	s, or trends that may indicate			an incluent report. No new	<b>J</b> 1	
	need for reporting						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED		
		245465	B. WING		04/17/2014
	ROVIDER OR SUPPLIER	=	STF 410 OS	·	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 225	needed are involved Interviews with responsibilities addition, the facility of every report immust be given to COHFC (state agent complaints) immediated in the supervision of every report immust be given to COHFC (state agent complaints) immediated in the supervision of the supervision of the supervision of the supervision of the disqualified, the Diagram of the disqualified of the disquality inform the individual review of the disqual request to Departrict individual may not residents unless proposed facility in the supervision of the disquarement of humber of the supervision	risor, DON, and other staff as ed in the investigation. ident, family, and staff are elebest understanding of the ed to report suspected vulnerable adult to the on duty or social services. In yladministrator must be notified inediately initial incident report CEP (common entry point) and cyloffice of health facility diately after knowledge of the diwhere there is reason to is or has been maltreated or a ined a physical injury which is plained The individual is epartment of Human Services and the individual and shall all of the right to request a utilification by submitting the ment of Human Services. This have further contact with the ermitted by the commission. Sible for cooperating with the man services. Therefore, an disqualified will be terminated	F 225	unexplained injuries were noted.  The care plans of the affectoresidents 44, 50, 34 and 53 along with the 4 other reside which were determined to brisk had their care plans reviewed and updated on 4/16/14 to include a more focused "behavior plan". The plan has resident specific interventions for the direct staff to use when/if the resident displays aggressive behaviors.  The nursing assistant who he been disqualified from DHS suspended without pay on 4/16/14 pending the appear process and was terminated from employment with the facility on 4/24/14 upon the notification that the appeal been denied and the employment was disqualified from proving the suspendent of the suspendent and the employment was disqualified from proving the suspendent and the employment was disqualified from proving the suspendent and the employment was disqualified from proving the suspendent and the employment was disqualified from proving the suspendent and the employment was disqualified from proving the suspendent and the employment was disqualified from proving the suspendent and the employment was disqualified from proving the suspendent and the employment was disqualified from proving the suspendent and the employment was disqualified from proving the suspendent and the employment was disqualified from proving the suspendent and the suspenden	ents pe at  is care  ad was  l d had yee ding
	identified the residence resistive with care	lent had behaviors of being s and can become physically essive, and will strike out during		services to persons receivin benefits from DHS.	g

		A. BUILDII	۷G	INSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245465	B. WING _			04	/17/2014
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		WEST MAIN STREET		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL SENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 225 Continued From page 27 cares. The interventions in doing cares, check/ change better if one person holds her with explanations/ soc conversation to distract from During interview on 4/15// practical nurse (LPN)-C s' "difficult" resident to provide cares to R44 it may to ensure cares can be conchange the resident's bried R44's hands down. LPN-on R44 to quickly "get the is difficult to redirect the respector of January 1, 2 DON stated injury reports were shredded. Review of revealed the following incomposition of a thorough investigation administrator or state age.  -An injury report dated 3/2 revised on 4/14/14, identificant incontinent BM [bowel most combative with AM [morn out at staff. Staff was hold prevent her from digging at staff. At lunch bruises was unaware." A Wound form dated 3/2/14, identification greasuring 3.5 cr wrist bruising measuring assessment indicated the being used were, "Try to	ge in bed; may work her hands and engages of thing words/ om the cares."  14, at 8:50 a.m. licensed tated R44 can be a de cares to related to LPN-C stated in order to ay require up to 3 staff of and one staff to hold C stated it is just easier cares done" because it esident once she  ovided R44's injury 014, to present. The prior to January 1, 2014 of injury reports for R44 idents lacked evidence n or reporting to the ency (SA):  2/14, which had been fied R44, "had ovement] and was ing] cares. Was hitting iding onto her hands to into BM and striking out were noted. Resident Assessment/ Monitoring ied R44 had left wrist m x 5.2 cm and right 3.6 cm x 2.8 cm. The e specific interventions	F2	225	Skin audits were started the week of 4/21/14 for the 8 residents above which will occur 3 times a week for 60 days. The remaining reside in the facility will have week skin audits done for 60 day assure that all residents are being monitored for unknowinjuries. The 8 residents about which were determined to risk for injury are being auditive weekly during cares to monitor the direct care stall and resident interaction which were determined to risk for injury are being auditive weekly during cares to monitor the direct care stall and resident interaction which weekly for 30 days from 4/21/14 and then weekly for 30 days.  As of 5/16/14, all nursing so have been assigned two education sessions called "Abuse Prevention In Personal With Dementia: The Basics "Client Behaviors: Assessmand Intervention in the	onts kly s to wn ove be at dited co ff hile hese or	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		DISTRUCTION	(X3) DATE SURVEY COMPLETED	
		245465	B. WING			04/	17/2014
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		NEST MAIN STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	resident when comban note dated 3/3/14, incombation badly bruised." There regarding which staff there any interviews a to determine if the resabused/mistreated. The was not reported to the agency.  -An injury report for Reported to the agency and 3 cm x 3 cm and 4 cm and 5 cm and	tive." The nursing progress licated, "Both forearms was no further investigation was involved, nor were attempted with the resident sident was this injury of unknown origin the administrator or state.  44 dated 3/14/14, which had with investigation was a sisting resident with other resident to have 2 that in a color measuring 6 cm cm. NOC [night] nurse a very combative during with her hands and arms. In residents was no further gowhich staff was involved, terviews attempted with the if the resident was his injury of unknown origin the administrator or state.  415/14, at 9:35 a.m. NA-D inve with staff when they are a resident. NA-D stated the lone staff assist with cares, required to help so one dents hands down when NA-D stated she knows sing on resident's wrists/ in holding them down when	F	225	Resident with Dementia" from the online education system, "Healthcare Academy". The staff have until June 6th, 2011 to complete the required education courses until discipline is enforced by administration.  The following system change have taken place since 4/16/16 A new facility Incident investigative form was developed and implemented which includes a review of the incident, interview of staff involved, and care plan interventions. All members of the IDT review and sign off on the incident including the facility administrator Monday through Friday and daily by a RN. The administrator will be notified immediately of any verportable incidents per the Vulnerable Adult Policy and Procedure on all days of the	4 s 14- e f n	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED
		245465	B. WING	· · · · · · · · · · · · · · · · · · ·	04/17/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
F 225	to get the resident's copossible. NA-D stated resident's had develop them down to perform are just so fragile and when we are holding a month ago" R44 ned changed and was resident could be cleated as a hours later staff of bruising on "like perferenced and state of the resident had sever required extensive as rejected care 4-6 days assessment period.  R50's care plan, updates and physical resistant reach out and grab at The interventions inclusing cares, and atted or items to manipulate on thems to manipulate on the state of the process when providing the state of the process of the process when providing cares, and atted or items to manipulate on the state of the process of R50's Woutform, dated 4/3/14, ideforearm bruising measing length and 1 cm with the season assessing the process of the process of R50's Woutform, dated 4/3/14, ideforearm bruising measing length and 1 cm with the process of the process of R50's Woutform, dated 4/3/14, ideforearm bruising measing length and 1 cm with the process of the proce	ares done as quickly as d she felt "horrible" when bed bruising from holding a cares, but she stated "they struggling with us so much them." NA-D stated "about eded to have her brief istive. NA-D stated staff ints wrists/ hands so the aned up. NA-D stated about beerved R44's wrists had ct hand prints."  So dated 2/18/14, identified are cognitive impairment, sistance with all ADLs, and so of the 7 look back  atted 4/14/14, identified the with cares, wanders, verbal be with cares, and may other people in her path, anded allow time for thoughting cares, keep her warm mpt to distract with music enher hands.  If was asked to provide by asked to provide of January 1, 2014, to atted R50 had no injury in and Assessment/ Monitoring	F 2	week including weekends. (4/16/14, The Resident Incident/Accident Policy and Procedure was updated to include these revisions. The Mood/Behavior Policy and Procedure was also updated the DON on 4/16/14 to include the addition of individualize "behavior plans" which will put into place if a resident in risk of injury related to aggressive behaviors. On 4/17/14 the DON, Administrator and LSW reviewed the facility Vulner Adult Policy and Procedure made multiple changes which include the addition of reference checks, suspension for employees under investigation by DHS, traininew employees with a focus Alzheimer's/dementia care staff burnout, and supporticare of the residents during pending investigation of an incident. On 4/17/14 the D	d by ude ed be s at  rable and ich on ng of as on , ve

STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S COMPL	
AND LEWIS OF	J.K.LO HOM					0.444	7/204 4
		245465  ATEMENT OF DEFICIENCIES	B. WING	ST 41 03	REET ADDRESS, CITY, STATE, ZIP CODE  0 WEST MAIN STREET  SAKIS, MN 56360  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	•	7/2014 (X5) COMPLETION
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR INTERPORT OR IN	y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  a 30  distrator or SA.  /15/14, at 9:35 a.m. NA-D dive "all the time" with "any oprovide to the resident." storedirect the resident by R50 can not be redirected. The resident is "pretty stated the resident is "pretty stated the resident's bed is one staff stands above er arms down, and the other dents cares done. NA-D mold her down to get her rould never get done." NA-D the resident's behaviors to the time" but nothing is ever or R50 any easier. NA-D tright [to hold residents do you do cares?"	PREF TAG	ıx		e De	
	resident had modera required extensive a rejected care 1-3 day assessment period.  R34's care plan, date resident is verbally a cares. The intervent reapproach with differeport to nurse cause when behavior is extended what is behavior with reside	aintained and resident happening, set limits for nt. If non-compliant and safe, pehavior stops. Reapproach			are aware that all incidents need to be thoroughly investigated to find root cause and to assure that the investigation component is complete.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245465	B. WING		04/17/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 225	During interview on stated R34 is combastated R34 is combastated staff will some resident later to prowork they will need with holding the resiprovide the cares. It R34's arms and legal cares done on R34.  On 4/14/14, the facing reports from Januar DON stated injury report was dated 1/20/14. The have bruising to bilate had increased physicares, including hittiwith fists, bare hand transfers." The imm "Monitor bruising unapproach when any further investigation the administrator or origin.  Review of R34's World identified the following that lacked evidence or reporting to administrator or complete than a complete th	A/15/14, at 8:50 a.m. LPN-C ative with cares. LPN-C etimes try to reapproach the vide cares, but, if that doesn't to have extra staff to assist dent's arms and legs to LPN-C stated often holding is down is the only way to get lity provided R34's injury by 1, 2014, to present. The exports prior to January 1, d.  As provided for R34 which was a report indicated, "Noted to ateral arms and wrists, has ical behaviors with staff duringing at staff and hitting PAL lift is typically during cares and ediate action taken was, with healed. Leave and revery with cares." There was no or evidence of reporting to SA the injury of unknown origin the of a thorough investigation inistrator and SA: earm bruising 3.5 cm x 2.3 conitoring form identified the	F 22	Risk meetings will be held monthly starting in May 2 and will have a focus on reviewing incidents/accid and individual resident caplans to address behavior and interventions. This mwill continue indefinitely the trends developed by team will be brought fort discussed during the facil QA&A meetings. The administrator will audit to sure that the incident repand risk meeting notes are brought to the QA meeting review by the team.  The corrective action for was completed on 5/16/3	ents re plans eeting and this h and ity's o make eorts re ngs for

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245465	B. WING_			04/	17/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 410 WEST MAIN STREET OSAKIS, MN 56360	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI: TAG		I SHOULD BE		(X5) COMPLETION DATE
F 225	multiple to left arm. Ein color. Discontinue Resident may be burn-1/11/14- Right forear around the edges of the fading in the middle. bruise." -1/20/14- Left back has bruising. "Has one pet the left hand and has her forearm."  During interview on 4 stated R34 is often constated it will often take cares because one has the other staff is proving R34 is very combative because she doesn't R53's annual MDS daresident had moderat required extensive as rejected care 1-3 days assessment period.  R53's plan of care days assessment period.  During interview on 4 stated R53 is often constated R53 is often constated she does not wishen she has she has	Bruises are dark blue/ purple mobility bars in bed. hping her arms on these." m bruising. "Dark purple bruising. Appears to be Yellow color to middle of and bruising and left arm enny sized bruise present on multiple bruises present on multiple bruises present on multiple bruises present on multiple bruises present on with cares. NA-A erafew of us" to provide as to hold her hands while ding the cares. NA-A stated even males provide cares like men to take care of her.  Atted 1/9/14, identified the eracy consistence with ADLs, and sof the 7 day look back atted 4/14/14, identified the ells if "painful, [did not heant] wants attention, or for some redirectable" The ask the resident why he is for staff, but if not cooperative with R53 often, but	F	225			

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG			(X3) DATE SURVEY COMPLETED	
		245465	B. WING_			04/	17/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 410 WEST MAIN STREET OSAKIS, MN 56360	E			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE		(X5) COMPLETION DATE	
F 225	Continued From page provide cares due to combative.		F2	225		:		
	reports from January	r provided R53's injury 1, 2014, to present. The orts prior to January 1,						
	dated 3/2/14, with a re which identified the re HS [bedtime] cares, to Abrasion noted to left completed Checked edges." A Wound Ass Report identified R53 abrasion(s) measuring x 0.3 cm. The interve for any sharp edges." investigation regarding nor were there any intresident to determine abused/mistreated.	PAL and bed for sharp sessment and Monitoring had (2) left antecubital g 1.3 cm x 0.7 cm and 1 cm ntions listed were, "Check There was no further g which staff was involved, erviews attempted with the						
	stated R53 was comb about anytime you try NA-D stated two staff but if he is combative reapproach him later. back and R53 is still c	15/13, at 9:35 a.m. NA-D ative with cares and "just to do something with him." can usually "handle him," staff tries to walk away and NA-D stated if staff comes ombative, staff will need to hands/ legs] to do cares. what we have to do to						
		dated 3/6/14, identified the cognitive impairment and						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		245465	B. WING _			04/17/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 410 WEST MAIN STREET OSAKIS, MN 56360	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BI D TO THE APPROPRIA CIENCY)	
F 225	required extensive as R16's care plan dated resident was resistive staff to report to nurse relationships when be A facility injury report 3/11/14, NA-D and N/ to the resident and the noise while doing carrincident contained the"had cleaned inco backside and were at as there was a significant traveled up into p started to gently spreknees to allow her pa area she felt a 'pop and the nurse was im room Resident was ambulance placed of staff an update on income femur."  During interview on 4 stated she did not repstate agency because story of what happene "horrible." The DON tracking which staff winjuries /bruising/ incident staff pattern. DON disqualified from work Department of Human be providing resident direct supervision.	sistance with all ADL.  d 3/18/14, identified the with cares and instructed exause and effect chavior was exhibited.  dated 3/11/14, identified on A-A were providing peri care ey said they heard a "pop" es. The summary of the existence following: Intinent bowels off her tempting to clean her front cant amount of stool that bubic region. As one staff ad legs slightly apart at the ritner to access to clean peri tempting to hospital via call to [hospital] and gave dident and fracture of left wort R16's fracture to the existence that the staff had the same end and they both felt werified she had not been ere involved in resident dents to ensure there was	F2	225		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI	TIPLE CONSTRUCTION  NG		DATE SURVEY COMPLETED
		245465	B. WING			04/17/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 410 WEST MAIN STREET OSAKIS, MN 56360	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 225	she would ensure the ensure healing. LPN staff needed to hold of provide cares and waresulted from staff restated she did not thi investigation or report the bruising was related she was award combative. LPN-C sepecially if it is known from.  During interview on 4 stated she was award combative residents stated if a resident is cares staff should lear eapproach. DON stated one for these residents "who are diresidents "who are diresidents has dementimated be resisted to a staff was restraining to make sure the resion injuring themselve report's of bruising warelated to "combative bruising was not susfull investigation or reor state agency, becare where the bruising care where the bruising care staff saff was restraining to resident the sure the resion of state agency, becare where the bruising care is a point well where the bruising care where the bruising care is a point well investigation or reor state agency, becare the bruising care in the staff was restraining to state agency, becare the bruising care in the staff was restraining to state agency, becare the bruising care in the staff was restraining to the staff was restraining to make sure the residents.	as observed with bruising be bruising was monitored to l-C stated she was aware combative resident's down to as aware bruising had straining resident's. LPN-C nk the bruising required ting because she was aware ted to the resident being tated an injury/ incident	F	225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		E SURVEY IPLETED
	245465	B. WING_		0,	1/17/2014
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CO 410 WEST MAIN STREET OSAKIS, MN 56360		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
abused as she felt the to care for the difficult to care for the difficult to care for the difficult.  During interview on 4. administrator stated had were receiving bruising restraining them to prove administrator stated if abuse occurring in the him immediately. Background Study The employee file of I was found in the file, the background study informed the facility the disqualified from any contact with or access services from state reletter also informed the to allow the person to services pending a podecision by the Commithis option they must obtain from the enotice of disqualificating reason for the disqual Ensure the employer reconsideration within notice of disqualification.  Ensure the employer grows with persons your program, pending disqualification.  An interview with hum completed on 4/16/14	If the residents were being e staff were doing their best thresidents.  In 16/14, at 1:30 p.m., facility he was not aware residents and from the staff holding and ovide cares. The fine DON thought their was defacility, she would notify  NA-D was reviewed. A letter dated 2/27/14, referencing for NA-D. The letter he employee had been position that allowed direct as to persons who received egulatory agencies. The he facility that it may choose a provide direct contact hossible reconsideration hissioner and if they chose do the following: employee a copy of the fon which explained the liftication; by erequested an 30 days of receiving the fon and; by every was under continuous, en providing direct contact are receiving services from greconsideration of the following:	F2	225		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/06/2014 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ 245465 B. WING 04/17/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET COMMUNITY MEMORIAL HOME **OSAKIS, MN 56360** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 225 Continued From page 37 F 225 since 9/5/13, and the initial Background Study results were received by the facility on 9/11/13, which did not indicate any problem with the employee providing cares for resident's. HR-A verified he had received the disqualification letter around 2/27/14, and reported he gave a copy of the letter to the DON. He reported he was unsure of what happened after she (DON) received the letter. He did verify the employee was still employed at the facility and he thought NA-D was still providing care to the resident's. An interview with the DON was completed on 4/16/14, at 2:14 p.m. She reported she was not aware why the employee (NA-D) had been disqualified from providing care and services for the resident's at the facility. She reported when she received the disqualification letter she met with the employee (on approximately 2/27/14) and was told by NA-D she had also received the letter of disqualification but the reason for the disqualification was not given. The DON reported the employee was sent home and did not return to work until after proof was obtained of the employee mailing information to the regulatory agency requesting reconsideration. The DON reported the facility provided the employee with a letter of reference and a current job evaluation completed by the DON, which the DON indicated accompanied the request for reconsideration of the disqualification. The employee then returned to work at the facility, under the supervision of a licensed practical nurse (LPN). A second interview with the DON was completed on 4/16/14, at 2:45 p.m. The DON reported NA-D was allowed to return to work after she met the requirements as the DON understood them.

The DON reported she did not contact the regulatory agency but had been told the

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245465	B. WING			04/	17/2014	
	ROVIDER OR SUPPLIER			410	REET ADDRESS, CITY, STATE, ZIP CODE DWEST MAIN STREET SAKIS, MN 56360	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE.	(X5) COMPLETION DATE	
F 225	DON was unable to re of this. The DON aga why the employee had not been given a copy employee specifying the disqualification. The NA-D provided service residents, independent doors. She acknowled duty was to supervise acknowledged no spirelated to any special. An interview with the completed on 4/16/14 interview, NA-D report would be disqualified. Background Division the rationale over the denied she was sent rationale for the disquashe needed to provide recommendations from supervisor and two of the agency to reconsing reported she obtained them on 3/7/14, and pletter mailed to the Doallowed to return to we returned under supernand used the buddy staff that she worked "buddy system" mean cared for a group of reassigned to and that she babysitter." She repoindependently care folimitations. She verifications.	d direct supervision. The ecall who had informed her in stated she did not know debeen disqualified and had of of the letter from the the rationale for the DON acknowledged that es/personal cares to notly and behind closed dged the licensed nurse on the employee but ecial plan had been devised supervision for NA-D. DON and NA-D was at 3:05 p.m. During the ted "had no idea as to why I and she had contacted but they would not tell her phone. NA-D adamantly a letter explaining the alification. NA-D reported the EBI fingerprints, letters of me the DON, her direct her coworkers in order for der the disqualification. She if these items and mailed provided a receipt of the DON, after which she was ork. She indicated she vision of the LPN on duty ystem with the two other with. NA-D indicated the not the nursing assistant's esident's they were	F	225				

PRINTED: 05/06/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING_			04/	/17/2014
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		WEST MAIN STREET		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 225 F 226 SS=F	An interview with the completed on 4/16/1 acknowledged he was disqualification letter acknowledged he was the facility and was vindependently while to the reconsideration. When asked as to the direct supervision," If 483.13(c) DEVELOF ABUSE/NEGLECT,  The facility must developolicies and proceed mistreatment, neglecand misappropriation.	door closed and she was bervision.  administrator was 4, at 3:15 p.m. He as aware of the related to NA-D. He also as aware she had returned to working with resident's waiting for a decision related in of the disqualification.  e definition of "continuous are did not respond.  PIMPLMENT ETC POLICIES		225	F226 Plan of correction 5/16/14  Resident 44, 50, 34, and 53 were assessed for bruising of 4/16/14 which was not correlated to any documents		
	facility failed to ensure R50, R34, R53, and injuries of unknown and/or injury resulting were thoroughly inversed immediately state agency per fact Vulnerable Adult Pol Prevention Plan lact the resident during a be supervised during	and document review, the re 5 of 5 residents (R44, R16) who experienced origin, potential staff abuse, and from staff providing cares estigated, tracked, and y to the administrator and illity policy. The facility icy and Procedure/sed instruction on protecting an investigation, how staff will gan investigation, definition burnout, training on how to			incidents. No injuries were noted on residents 44 and 53 Bruising, not correlated with incident was located on resident 50 and 34 which we immediately filed to OHFC afthe facility administrator was updated.	3. an re ter	

Event ID: 5L8E11

PRINTED: 05/06/2014 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 226  Continued From page 40 deal with resident aggression, and obtaining reference checks on employees before beginning employment.  In addition, the facility failed to check professional or personal references for 7 of 10 nursing assistants in the sample (NA-I, NA-J, NA-D, NA-E, NA-C, NA-K, & NA-L) who had direct resident contact per facility policy, the facility also failed to provide adequate supervision for 1 of 1 nursing assistant (NA)-D, who was disqualified from providing personal cares for residents. This had the potential to affect all 40 residents residing in the facility that NA-D assisted with cares.  STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360  STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360  PROVIDERS PLAN OF CORRECTION (CS)  PROVIDERS PLAN OF CORRECTION (CS)  PROVIDERS PLAN OF CORRECTION (CS)  (CACH CORRECTIVE ACTION SHOULD BE (CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 226  Resident 16 had skin audit performed on 4/26/14 which did not reveal any alterations in skin integrity or new injury.  Resident #16 is alert and was interviewed by the DON shortly after incident on 3/11/14 prior to her transport to hospital.  Resident had denied staff abuse, but moving forward, a vulnerable adult will be filed for		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION (X3) DATE SURV COMPLETE	
COMMUNITY MEMORIAL HOME    A10 WEST MAIN STREET OSAKIS, MN 56360			245465	B. WING		04/17/2014
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 226  Continued From page 40 deal with resident aggression, and obtaining reference checks on employees before beginning employment.  In addition, the facility failed to check professional or personal references for 7 of 10 nursing assistants in the sample (NA-I, NA-D, NA-E, NA-C, NA-K, & NA-L) who had direct resident contact per facility policy, the facility also failed to provide adequate supervision for 1 of 1 nursing assistant (NA)-D, who was disqualified from providing personal cares for residents. This had the potential to affect all 40 residents residing in the facility that NA-D assisted with cares.  F 226  Resident 16 had skin audit performed on 4/26/14 which did not reveal any alterations in skin integrity or new injury.  Resident #16 is alert and was interviewed by the DON shortly after incident on 3/11/14 prior to her transport to hospital.  Resident had denied staff abuse, but moving forward, a vulnerable adult will be filed for					410 WEST MAIN STREET	
deal with resident aggression, and obtaining reference checks on employees before beginning employment.  In addition, the facility failed to check professional or personal references for 7 of 10 nursing assistants in the sample (NA-I, NA-J, NA-D, NA-E, NA-C, NA-K, & NA-L) who had direct resident contact per facility policy, the facility also failed to provide adequate supervision for 1 of 1 nursing assistant (NA)-D, who was disqualified from providing personal cares for residents. This had the potential to affect all 40 residents residing in the facility that NA-D assisted with cares.  Resident 10 flad skin addit performed on 4/26/14 which did not reveal any alterations in skin integrity or new injury.  Resident 10 flad skin addit performed on 4/26/14 which did not reveal any alterations in skin integrity or new injury.  Resident 10 flad skin addit performed on 4/26/14 which did not reveal any alterations in skin integrity or new injury.  Resident 10 flad skin addit performed on 4/26/14 which did not reveal any alterations in skin integrity or new injury.  Resident 10 flad skin addit performed on 4/26/14 which did not reveal any alterations in skin integrity or new injury.  Resident 10 flad skin addit	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE COMPLETION
Findings include:  The facility Vulnerable Adult Policy and Procedure/ Prevention Plan dated 2/3/12, indicated Injury of Unknown Source: An injury should be classified as an injury of unknown source when both of the following conditions are met:  1.) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident and  2.) The injury is suspicious because of the extent of the injury or the location of the injuryor the number of injuries observed at one particular point in time or incident of injuries over time Incident reports are required for bruises, skin tears, etc., of unknown origin. The DON [director of nursing]/ case manager will look for possible reason for the bruising while also watching for patterns, occurrences, or trends that may indicate need for reporting The administrator, department supervisor, DON, and other staff as needed are involved in the investigation. Interviews with regitent family, and staff are	F 226	deal with resident ag reference checks on employment.  In addition, the facilit or personal reference assistants in the sam NA-E, NA-C, NA-K, aresident contact per failed to provide adenursing assistant (Nafrom providing personad the potential to a in the facility that NAFindings include:  The facility Vulnerab Procedure/ Preventice indicated Injury of Urshould be classified source when both of met:  1.) The source of the any person or the sobe explained by the indicated Injury or the lonumber of injuries ob point in time or incident reports are rears, etc., of unknow of nursing]/ case ma reason for the bruisir patterns, occurrence need for reporting department supervis needed are involved	gression, and obtaining employees before beginning by failed to check professional es for 7 of 10 nursing aple (NA-I, NA-J, NA-D, & NA-L) who had direct facility policy, the facility also quate supervision for 1 of 1 A)-D, who was disqualified anal cares for residents. This affect all 40 residents residing and cares for residents residing and passisted with cares.  Ile Adult Policy and by the facility also quate supervision for 1 of 1 A)-D, who was disqualified anal cares for residents. This affect all 40 residents residing and provide the following conditions are the injury was not observed by the following conditions are the injury was not observed by the end of the injuryor the provide the injuryor the provide for bruises, skin who origin. The DON [director nager will look for possible and while also watching for its, or trends that may indicate the administrator, or, DON, and other staff as in the investigation.	F 22	performed on 4/26/14 will did not reveal any alterative skin integrity or new injuring Resident #16 is alert and interviewed by the DON stafter incident on 3/11/14 to her transport to hospite Resident had denied staff abuse, but moving forward vulnerable adult will be fill any fracture which is obtaining cares.  All residents in the facility discussed on 4/15/14 and 4/16/14 with both IDT and direct care staff and 4 other residents in the facility will determined to be at a high risk of obtaining injury reto their combative and aggressive behaviors. The other residents were also assessed on 4/16/14 for it which were not document.	hich ions in ry. was shortly prior tal. f rd, a iled for ained  y were d d her ere sher lated  njuries ated in

Facility ID: 00109

PRINTED: 05/06/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı		CONSTRUCTION	(X3) DATE COME	SURVEY PLETED
			A. BUILDI				
		245465	B. WING			04	/17/2014
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
COMMUN	ITY MEMORIAL HOME		ĺ		O WEST MAIN STREET		1
				0	SAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
					unexplained injuries were		
F 226	Continued From page		F:	226	noted.		
	solicited to gain the be event All staff need	est understanding of the		İ	The care plans of the affected		
	maltreatment of a vulr				residents 44, 50, 34 and 53		
		duty or social services. In			along with the 4 other residents		
		dministrator must be notified liately initial incident report			which were determined to be at		
	must be given to CEP	(common entry point) and			risk related to aggressive		
	OHFC (state agency/ complaints) immediate	office of health facility ely after knowledge of the			behaviors had their care plans		
	incident is received w	here there is reason to			reviewed and updated on		
		r has been maltreated or a d a physical injury which is			4/16/14 to include a more		
	not reasonably explain				focused "behavior plan". This		
	1 , ,	rtment of Human Services the individual and shall			plan has resident specific		
		of the right to request a			interventions for the direct care		
	•	ication by submitting the tof Human Services. This	ļ	ĺ	staff to use when/if the		
		ve further contact with the		ļ	resident displays aggressive		
	[facility] is responsible	itted by the commission. for cooperating with the			behaviors.		
		services. Therefore, an ualified will be terminated	1		The nursing assistant who had		
	, -				been disqualified from DHS was		
	R44's quarterly Minim	um Data Set (MDS) dated		Ì	suspended without pay on		
	1/16/14, identified the	resident had severe			4/16/14 pending the appeal		
	cognitive impairment, assistance with activit	required extensive ies of daily living (ADL), and			process and was terminated		
	rejected care 4-6 days	s of the 7 day look back			from employment with the		
	assessment period.				facility on 4/24/14 upon the		
	R44's care plan last u				notification that the appeal had		
		had behaviors of being and can become physically			been denied and the employee		
		ve, and will strike out during			was disqualified from providing		
	cares. The interventio	ns instruct staff, "when			services to persons receiving		
	=	nange in bed; may work olds her hands and engages			benefits from DHS.		

Facility ID: 00109

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245465	B. WING			04	1/17/2014
	ROVIDER OR SUPPLIER		- · · · · · · · · · · · · · · · · · · ·	410	REET ADDRESS, CITY, STATE, ZIP CODE 0 WEST MAIN STREET SAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 226	her with explanations conversation to distrate the conversation to distrate the practical nurse (LPN) "difficult" resident to pher combative behave provide cares to R44 to ensure cares can be change the resident's R44's hands down. It can be comes agitated.  On 4/14/14, the facility reports from January DON stated injury reports from January DON stated injury reports administrator or state administrator or state.  -An injury report date revised on 4/14/14, in incontinent BM [bower combative with AM [rout at staff. Staff was prevent her from digg at staff. At lunch bruwas unaware." A We form dated 3/2/14, in bruising measuring 3 wrist bruising measuring 3 wrist bruising measuring assessment indicate being used were, "Tresident when combinate dated 3/3/14, in	/ soothing words/ lect from the cares."  /15/14, at 8:50 a.m. licensed -C stated R44 can be a crovide cares to related to ior. LPN-C stated in order to it may require up to 3 staff be completed, 2 staff to so brief and one staff to hold LPN-C stated it is just easier at the cares done" because it the resident once she  ty provided R44's injury 1, 2014, to present. The borts prior to January 1, 2014 iew of injury reports for R44 g incidents lacked evidence gation or reporting to the e agency (SA):	F	226	Skin audits were started the week of 4/21/14 for the 8 residents above which will occur 3 times a week for 60 days. The remaining resider in the facility will have week skin audits done for 60 day assure that all residents are being monitored for unknowinjuries. The 8 residents about which were determined to risk for injury are being auditive weekly during cares and resident interaction which were being provided. The audits will continue twice weekly for 30 days from 4/21/14 and then weekly for the following 30 days.  As of 5/16/14, all nursing shave been assigned two education sessions called "Abuse Prevention In Person with Dementia: The Basics" Client Behaviors: Assessmand Intervention in the approximate the series of	nts kly s to e wn ove be at dited ff nile These or	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245465	B. WING				04/17/2014
	ROVIDER OR SUPPLIER	1		410	EET ADDRESS, CITY, STATE, ZIP CODE WEST MAIN STREET AKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 226	regarding which staff there any interviews to determine if the reabused/mistreated. was not reported to tragency.  -An injury report for Fibeen revised on 4/14 [nursing assistant] wher A.M. cares they ribruises to her left for bruises to be dark pux 3 cm and 3 cm x 3 reported resident was cares and hitting staff is likely bruising is frought to determine abused/mistreated. The investigation regarding nor were there any investigation regarding to determine abused/mistreated. The was not reported to tragency.  During interview on a stated R44 is combative and reported to tragency.  During interview on a stated R44 is combative and the resident only require but usually 2 staff ar staff can hold the resident only require but usually 2 staff ar staff can hold the resident only require but usually 2 staff ar staff can hold the resident only require but usually 2 staff ar staff can hold the resident only require but usually 2 staff ar staff can hold the residents and ankles from staff were trying to gresidents are so residents. NA-D staff possible. NA-D staff	was involved, nor were attempted with the resident sident was This injury of unknown origin he administrator or state  R44 dated 3/14/14, which had wide, identified, "When NA ere assisting resident with noted resident to have 2 earm. Author observed urple in color measuring 6 cm cm. NOC [night] nurse s very combative during if with her hands and arms. Our residents ere was no further nig which staff was involved, interviews attempted with the	F	226	Resident with Dementia" for the online education system "Healthcare Academy". The staff have until June 6th, 2 to complete the required education courses until discipline is enforced by administration.  The following system charman have taken place since 4/2 A new facility Incident investigative form was developed and implement which includes a review of incident, interview of staff involved, and care plan interventions. All member the IDT review and sign of the incident including the facility administrator More through Friday and daily the RN. The administrator will notified immediately of a reportable incidents per the Vulnerable Adult Policy and sign of the staff incidents per the vulnerable Adult Policy and sign of the staff incidents per the vulnerable Adult Policy and sign of the staff incidents per the vulnerable Adult Policy and sign of the staff incidents per the vulnerable Adult Policy and sign of the staff incidents per the vulnerable Adult Policy and sign of the staff incidents per the vulnerable Adult Policy and sign of the staff incidents per the vulnerable Adult Policy and sign of the staff incidents per the vulnerable Adult Policy and sign of the staff incidents per the vulnerable Adult Policy and sign of the staff incidents per the vulnerable Adult Policy and sign of the staff incidents per the vulnerable adult Policy and sign of the staff incidents per the vulnerable adult Policy and sign of the staff incidents per the vulnerable adult Policy and sign of the staff incidents per the vulnerable adult Policy and sign of the staff incidents per the vulnerable adult Policy and sign of the staff incidents per the vulnerable adult Policy and sign of the staff incidents per the vulnerable adult Policy and sign of the staff incidents per the vulnerable adult Policy and sign of the staff incidents per the vulnerable adult Policy and sign of the staff incidents per the vulnerable adult Policy and sign of the staff incidents per the vulnerable adult Policy and sign of the staff incidents per the vulnerabl	em, ne 2014 nges 16/14 ted f the f ff on nday oy an il be ny VA	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		001111	
		245465	B. WING		04/	17/2014
NAME OF P	ROVIDER OR SUPPLIER		- 1	STREET ADDRESS, CITY, STATE, ZIP CODE		
COMMUN	ITY MEMORIAL HOME			410 WEST MAIN STREET OSAKIS, MN 56360		
0/1/5	CI IMMADV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRI	ECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	COMPLETION DATE
F 226	Continued From page	e 44 n cares, but she stated "they	F 226	Procedure on all days of th	ıe	
		d struggling with us so much		week including weekends.	. On	
	_	them." NA-D stated "about		4/16/14, The Resident		
		eded to have her brief sistive,NA-D stated staff		Incident/Accident Policy a	nd	
	_	ents wrists/ hands so the		Procedure was updated to		
		aned up. NA-D stated about		include these revisions. Th		
	2-3 hours later staff of bruising on "like perfe	observed R44's wrists had		Mood/Behavior Policy and		
	bruising on the porte	socriana printo.		Procedure was also update		
		S dated 2/18/14, identified		the DON on 4/16/14 to inc		
	l .	ere cognitive impairment, ssistance with all ADLs, and				
	rejected care 4-6 day			the addition of individualis		
	assessment period.			"behavior plans" which wi		
	R50's care plan, upda	ated 4/14/14, identified the		put into place if a resident	t is at	
	resident was resistive	e with cares, wanders, verbal		risk of injury related to		
		ce with cares, and may tother people in her path.		aggressive behaviors. On		
	_	luded allow time for thought		4/17/14 the DON,		
	process when providi	ing cares, keep her warm		Administrator and LSW		
	during cares, and attement or items to manipulat	empt to distract with music		reviewed the facility Vulne	erable	
	or items to manipulat	e nei nanos.		Adult Policy and Procedur	e and	
		ty was asked to provide		made multiple changes w	hich	
	R50's injury reports fi	rom January 1, 2014, to tated R50 had no injury		include the addition of		
	reports/ investigation			reference checks, suspens	sion	
				for employees under	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	Review of R50's Would form, dated 4/3/14, ic	und Assessment/ Monitoring  Hentified R50 had left		investigation by DHS, train	ning of	
	forearm bruising mea	asuring approximately 6 cm				
	in length and 1 cm w	ide; reddish/ purple in color.		new employees with a foo		
	There was no assess	sment or investigation of the unknown origin was not		Alzheimer's/dementia car		
	reported to the admir	nistrator or SA.		staff burnout, and suppor		
				care of the residents duri	ng	
	During interview on 4	1/15/14, at 9:35 a.m. NA-D				L

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING			04/	17/2014	
	ROVIDER OR SUPPLIER	<b>A</b>		41	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET SAKIS, MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC !DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	38	(X5) COMPLETION DATE	
F 226	cares staff attempts to NA-D stated staff tries talking with her, but F NA-D stated sometime the resident's brief being and strong." She against the wall, and R50's head to hold he two staff get the residestated, "We have to heare done or they we stated she reports the charge nurse "all the done to help caring for stated, "I know it isn't down] but how else down? but how else down? Bayes as rejected care 1-3 day assessment period.  R34's care plan, date resident is verbally as cares. The intervention reapproach with differe port to nurse cause when behavior is exhibit communication is maunderstands what is behavior with resident leave situation until but later "verbally deman".	ive "all the time" with "any or provide to the resident." Is to redirect the resident by 150 can not be redirected. It is it takes 3 staff to change reases the resident is "pretty stated the resident's bed is one staff stands above or arms down, and the other ents cares done. NA-D hold her down to get her ould never get done." NA-D or eresident's behaviors to the time" but nothing is ever or R50 any easier. NA-D right [to hold residents or you do cares?"  I dated 2/13/14, identified the ere cognitive impairment, sistance with ADLs, and so of the 7 day look back  I d 2/27/14, identified the gressive and resistive to ons to be used were rent staff if refusing cares, and effect relationship ibited, assure good intained and resident mappening, set limits for t. If non-compliant and safe, eehavior stops. Reapproach	F	226	pending investigation of an incident. On 4/17/14 the DON contacted all licensed staff and informed them of the changes in the Vulnerable Adult Policy and Procedure and the revisions made to the Incident/Accident Policy and Procedure. A mandatory nursing staff meeting was held on 4/24/14 and a review of the revised incident/accident procedure was reviewed. All staff are aware that they are mandated reporters. If abuse has been suspected, a Vulnerable Adult report will be submitted immediately. All staff are aware that all incidents need to be thoroughly investigated to find root cause and to assure that the investigation component is complete.  On 5/16/14, a check box was added to new hire paperwork which includes a	•		
	stated staff will some	times try to reapproach the			prompt/reminder that a			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		245465	B. WING		04/17/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST 8E PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 226	resident later to proviwork they will need to with holding the resid provide the cares. LF R34's arms and legs cares done on R34.  On 4/14/14, the facilit reports from January DON stated injury report was dated 1/20/14. The rehave bruising to bilate had increased physic cares, including hitting with fists, bare hands transfers." The immed "Monitor bruising until approach when angry further investigation of the administrator or Sorigin.  Review of R34's Wouldentified the following that lacked evidence or reporting to admini -12/28/13- Right foreacm. Right forearm bruising was dark pur -1/6/14- Multiple bruis left hand [back] meas appearance indicated multiple to left arm. Ein color. Discontinue	de cares, but, if that doesn't have extra staff to assist ent's arms and legs to ent's the only way to get by provided R34's injury 1, 2014, to present. The orts prior to January 1, entered arms and wrists, has all behaviors with staff during goat staff and hitting PAL lift typically during cares and diate action taken was, healed. Leave and rewith cares." There was no revidence of reporting to A the injury of unknown end Assessment Monitoring goinjuries of unknown origin of a thorough investigation strator and SA: summor bruising 3.5 cm x 2.3 suising 9.5 cm x 5 cm x 0.2 toring form identified the pole. ing to left arm. Bruising to uring 4 cm x 6 cm. The "Bruising to hand and ruises are dark blue/ purple	F 22	reference check is needed. Thus in ess office staff will and make sure that a reference heen checked on all new him. Risk meetings will be held monthly starting in May 201 and will have a focus on reviewing incidents/acciden and individual resident care plans to address behavior plans to address behavior pland interventions. This mee will continue indefinitely and the trends developed by this team will be brought forth a discussed during the facility QA&A meetings. The administrator will complete audits to assure that the incident reports and Risk not have been brought to the Queeting and reviewed assure that adequate and appropriate reporting has occurred.  The corrective action for F2 was completed on 5/16/14	tt to has es.  4,  ts  ans ting d s nd s ring ate

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED	
		245465	B. WING			04/	17/2014
	ROVIDER OR SUPPLIER			41	REET ADDRESS, CITY, STATE, ZIP CODE 0 West main street Sakis, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	-1/11/14- Right forear around the edges of be fading in the middle. bruise." -1/20/14- Left back has bruising. "Has one pet the left hand and has her forearm."  During interview on 4 stated R34 is often constated it will often take cares because one has the other staff is proving R34 is very combative because she doesn't.  R53's annual MDS daresident had moderate required extensive as rejected care 1-3 days assessment period.  R53's plan of care daresident hollers and yidentify what painful in no reasonnot alway interventions included yelling, is a 1 assist of use 2 staff.  During interview on 4 stated R53 is often constated she does not with when she has she has	m bruising. "Dark purple bruising. Appears to be Yellow color to middle of and bruising and left arm enny sized bruise present on multiple bruises present on which is to provide as to hold her hands while ding the cares. NA-A stated when males provide cares like men to take care of her.  Inted 1/9/14, identified the ecognitive impairment, sistance with ADLs, and is of the 7 day look back ited 4/14/14, identified the eells if "painful, [did not heant] wants attention, or for is redirectable" The ask the resident why he is f staff, but if not cooperative with Cares. NA-A work with R53 often, but id to have extra staff esident's arms down to	F	226			

PRINTED: 05/06/2014 FORM APPROVED

OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245465	B. WING_			04/17/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 410 WEST MAIN STREET OSAKIS, MN 56360	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIAT		
F 226	reports from January DON stated injury rep 2014, were shredded dated 3/2/14, with a re which identified the re HS [bedtime] cares, the Abrasion noted to left completed Checked edges." A Wound As Report identified R53 abrasion(s) measurin x 0.3 cm. The interversion for any sharp edges. Investigation regarding nor were there any in resident to determine abused/mistreated. Was not reported to the agency.  During interview on 4 stated R53 was combabout anytime you try NA-D stated two staff but if he is combative reapproach him later. back and R53 is still crestrain him (hold his NA-D stated, "We do complete cares."  R16's quarterly MDS resident had moderat required extensive as	y provided R53's injury 1, 2014, to present. The corts prior to January 1, 1.  one injury report for R53 evision date of 4/14/14, esident was "combative with to thrashing arms in PAL. t arm after HS cares d PAL and bed for sharp sessment and Monitoring had (2) left antecubital g 1.3 cm x 0.7 cm and 1 cm entions listed were, "Check There was no further to which staff was involved, terviews attempted with the if the resident was This injury of unknown origin the administrator or state  1/15/13, at 9:35 a.m. NA-D to be to do something with him." I can usually "handle him," staff tries to walk away and NA-D stated if staff comes combative, staff will need to hands/ legs] to do cares. what we have to do to  dated 3/6/14, identified the e cognitive impairment and sistance with all ADL.	F 2	226			
	R16's care plan dated	3/18/14, identified the					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245465	B. WING			04	/17/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 410 WEST MAIN STREET OSAKIS, MN 56360	DE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	· · · · · · · · · · · · · · · · · · ·	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
	staff to report to nurse relationships when be A facility injury report 3/11/14, NA-D and NA to the resident and the noise while doing care incident contained the had cleaned incorbackside and were att as there was a signific had traveled up into postarted to gently spreaknees to allow her pararea she felt a 'pop' and the nurse was immore room Resident was ambulance placed costaff an update on incifemur."  During interview on 4/1 stated she did not repostate agency because story of what happene "horrible." The DON votracking which staff we injuries /bruising/ incid no staff pattern. DON disqualified from working Department of Human be providing resident of direct supervision.  During interview on 4/1 stated if a resident was stated if a resident	with cares and instructed cause and effect havior was exhibited.  dated 3/11/14, identified on the Awere providing peri care by said they heard a "pop" as. The summary of the following: attinent bowels off her empting to clean her front and amount of stool that subic region. As one staff and legs slightly apart at the ther to access to clean peri [R16] hollered out in pain mediately summoned to the transferred to hospital via all to [hospital] and gave dent and fracture of left  15/14, at 12:11 p.m. DON out R16's fracture to the the staff had the same d and they both felt erified she had not been are involved in resident ents to ensure there was verified NA-D was ng with resident's by the Services and was not to the sares on 3/11/14, without	F2	226			
		oruising was monitored to C stated she was aware					•

1		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	245465	B. WING		04/	17/2014
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		,
(X4) ID SUMMARY STATEMENT OF DE PREFIX (EACH DEFICIENCY MUST BE PRE TAG REGULATORY OR LSC IDENTIFYIN	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
staff needed to hold combative reprovide cares and was aware bruit resulted from staff restraining resistated she did not think the bruisir investigation or reporting because the bruising was related to the rescombative. LPN-C stated an injurt report is not always filled out for bespecially if it is known where the from.  During interview on 4/15/14, at 12 stated she was aware staff needed combative residents to do cares. stated if a resident is combative or cares staff should leave the resident reapproach. DON stated, "The care done for these residents" and their residents "who are difficult." She resident has dementia, there is a may be resistive with cares and si "cares done as quickly as possible residents, you cant just leave there brief and not get cares done." DO "There is a point we have to provik now that resident's are held dow staff was restraining residents for to make sure the resident's were or injuring themselves. DON verificated to "combative with cares." bruising was not suspicious and dull investigation or reporting to the or state agency, because the facil where the bruising came from an resident's "weren't being abused." she never considered the resident abused as she felt the staff were to care for the difficult residents.	dent's. LPN-C ng required e she was aware sident being y/ incident ruising, bruising came  2:10 p.m. DON d to restrain The DON r resistive with ent safe, and ares have to get re are just some stated when a risk the resident taff needs to get e for these m in a soiled DN stated, de cares and I n." DON stated their own safety mot striking staff fied injury red at times She stated this lid not require a re administrator ity was aware d knew the DON stated ts were being	F 22	6		

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	245465	B. WING _			04/17/2014
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP COD 410 WEST MAIN STREET OSAKIS, MN 56360	E	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
administrator stated haver receiving bruising restraining them to provide administrator stated if abuse occurring in the him immediately.  REFERENCE CHECHOM The employee file of the had worked at the factor provided direct reside was found in the perspersonal/professional contacted.  The employee file of the had worked at the factor provided direct reside was found in the perspersonal/professional. The employee file of the had worked at the factor provided direct reside was found in the perspersonal/professional. The employee file of the had worked at the factor provided direct reside was found in the perspersonal/professional. The employee file of the had worked at the factor provided direct reside was found in the perspersonal/professional. The employee file of the had worked at the factor provided file of the had worked at the factor p	/16/14, at 1:30 p.m., facility he was not aware residents and from the staff holding and ovide cares. The fithe DON thought their was a facility, she would notify will be a facility since 6/17/13, and not care. No documentation onnel file of references being contacted was reviewed. NA-E was reviewed. NA-C was reviewed.	F 2:	26		

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING			X3) DATE SURVEY COMPLETED		
		245465	B. WING		04/	17/2014
	ROVIDER OR SUPPLIER	•	41	REET ADDRESS, CITY, STATE, ZIP CODE 0 WEST MAIN STREET SAKIS, MN 56360	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	The employee file of had worked at the far provided direct reside was found in the personal/professional. The employee file of had worked at the far provided direct reside was found in the personal/professional contacted.  An interview with the 4/17/14, at 9:20 a.m. responsible to check references and shou employee they were unable to provide evireference's had been Background Study. The employee file of was found in the file, the background study informed the facility to disqualified from any contact with or accesservices from state reletter also informed the allow the person to pervices pending a pedecision by the Comthis option they must	NA-K was reviewed. NA-K cility since 9/20/13, and ent care. No documentation sonnel file of all references being contacted on NA-L was reviewed. NA-L cility since 12/10/13, and ent care. No documentation sonnel file of all references being on the care. No documentation sonnel file of all references being on the care. No documentation sonnel file of all references being on the care of the	F 226			
		employee a copy of the tion which explained the				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245465	B. WING_		0	4/17/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 410 WEST MAIN STREET OSAKIS, MN 56360	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI: TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 226	reason for the disqual reconsideration within notice of disqualificat.  Ensure the emploirect supervision whis services with persons facility, pending recondisqualification.  An interview with huncompleted on 4/16/12 verify the employee (since 9/5/13 and the result's were received which did not indicate employee providing overified he had received around 2/27/14 and gothe DON. He reported happened after she (did verify the employe facility and he though care to the resident's.  An interview with the 4/16/14, at 2:14 p.m. employee (NA-D) had providing care and set the facility. She reported in the facility is the responsible facility and he though care to the resident's.  An interview with the 4/16/14, at 2:14 p.m. employee (NA-D) had providing care and set the facility. She reported is a set of the facility is the reason for the given. The DON reported was obtained on information to the region of the region of the given. The DON reported was obtained on information to the region of the given.	lification. oyee requested in 30 days of receiving the ion. oyee was under continuous, en providing direct contact is receiving services from the insideration of the  man resources (HR)-A was if, at 12:02 p.m. HR-A did NA-D) had been employed initial Background Study if by the facility on 9/11/13, if any problem with the inares for residents. HR-A red the disqualification letter have a copy of the letter to id he was unsure of what DON) received the letter. He see was still employed at the it NA-D was still providing	F2	226			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING				04/17/2014	
	ROVIDER OR SUPPLIER			410 V	EET ADDRESS, CITY, STATE, ZIP CODE NEST MAIN STREET .KIS, MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 226	and a current job eva DON, which the DON request for reconside. The employee then reacility, under the surpractical nurse (LPN A second interview won 4/16/14, at 2:45 p NA-D was allowed to the requirements as The DON reported s regulatory agency be employee did not ne DON was unable to of this. The DON ag why the employee hand been given a copemployee specifying disqualification. The NA-D provided services ident's independed doors. She acknowledged no sprelated to any special DON verified she did about the reason for employee "privacy is the facility. An interview with the completed on 4/16/1 interview, NA-D repowould be disqualified Background Division the rationale over the denied she was sent rationale for the disqualified for the	ee with a letter of reference aluation completed by the lindicated accompanied the pration of the disqualification. The disqualification of a licensed lindicated accompanied the prevision of a licensed lindicated and licensed lindicated are return to work after she met at the DON understood them. The did not contact the literated lidicated she did not know and been disqualified and had by of the letter from the letter from the lices/personal cares to ently and behind closed ledged the licensed nurse on	F	226				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG		DATE SURVEY COMPLETED
		245465	B. WING			04/17/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 410 WEST MAIN STREET OSAKIS, MN 56360	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 226	she needed to provide recommendations fro supervisor, and two of the agency to reconsist reported she obtained them on 3/7/14 and pletter mailed to the DO was allowed to return returned under superfand used the buddy staff she worked with system" meant the neal group of residents to she did not need "a bocould and did indeper with no special limitat acceptable for her to	e FBI fingerprints, letters of m the DON, her direct f her coworkers in order for der the disqualification. She is these items and mailed rovided a receipt of the DN, after which time she to work. She indicated she vision of the LPN on duty ystem with the two other. NA-D indicated the "buddy ursing assistant's cared for hey were assigned to and abysitter." She reported she indently care for resident's, ions. She verified it was independently provide cares soms with the door closed	F	226		
F 250 SS=E	he was aware NA-D hand was working with while waiting for a decreconsideration of the asked as to the defini supervision," he did n 483.15(g)(1) PROVIS RELATED SOCIAL S  The facility must proviservices to attain or many sixth with the services and the services are not services.	at 3:15 p.m. He is aware of the related to NA-D. He stated and returned to the facility resident's independently cision related to the disqualification. When tion of "continuous direct of respond.  ION OF MEDICALLY ERVICE  ide medically-related social maintain the highest mental, and psychosocial	F2	250		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		245465	B. WING			04/	17/2014	
	ROVIDER OR SUPPLIER		•	4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET ISAKIS, MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 250	Continued From page	. 56	F	250	F250 Plan of correction on 5/16/14			
	by: Based on interview a facility failed to ensure combative with staff d in injuries/bruising (R4 were provided social sindividualized interver implemented to ensur not receive injury or a receiving cares from s  Findings include:  R44's quarterly Minim 1/16/14, identified the cognitive impairment, assistance with activit and rejected care 4-6 assessment period.  During interview on 4/practical nurse (LPN)-"difficult" resident to pher combative behavi provide cares to R44 2 staff to change the resident to redirect the becomes agitated.  R44's care plan last up identified the resident resistive with cares an and verbally aggressi	ntions were in place and the combative residents did buse/mistreatment while staff.  The place and the combative resident had severe required extensive states of daily living (ADLs), days of the 7 day look back of the 10 days of the 2 days look back of the 2 days look b			Resident 44, 50, 34, and 53 we assessed for bruising on 4/16/which was not correlated to an documented incidents. No injuries were noted on residen 44 and 53. Bruising, not correlated with an incident wallocated on resident 50 and 34 which were immediately filed OHFC after the facility administrator was updated.  All residents in the facility were discussed on 4/15/14 and 4/16/14 with both IDT and directore staff and 4 other resident the facility were determined to be at a higher risk of obtaining injury related to their combati and aggressive behaviors. The 4 other residents were also assessed on 4/16/14 for injurity which were not documented if an incident report. No new or unexplained injuries were not unexplained injuries were not unexplained injuries were not unexplained injuries were not assessed.	14 ny its is to e ect s in o ve sse es n		
		hange in bed; may work			unexplained injuries were not	ea.		

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	IPLE CONSTRUCTION IG		E SURVEY PLETED
	245465	B. WING_		04	/17/2014
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES NUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFI: TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
conversation to distract An injury report dated 3 revised on 4/14/14, ider incontinent BM [bowel rombative with AM [mo out at staff. Staff was horevent her from digginat staff. At lunch bruise was unaware." A Wour form dated 3/2/14, identifying measuring 3.5 wrist bruising measuring assessment indicated the being used were, "Try to the resident when combative indication the social work bruising related to being An injury report for R44 been revised on 4/14/14 [nursing assistant] were her A.M. cares they not bruises to her left foreatoruses to be dark purp x 3 cm and 3 cm x 3 cm reported resident was we cares and hitting staff which is likely bruising is from combativeness." Ther social worker had revied to being combative with During interview on 4/1 stated R44 is combative providing cares to the resident only required to but usually 2 staff are restaff can hold the resident only required to but usually 2 staff are restaff can hold the resident only required to but usually 2 staff are restaff can hold the resident only required to but usually 2 staff are restaff can hold the resident only required to but usually 2 staff are restaff can hold the resident only required to but usually 2 staff are restaff can hold the resident only required to but usually 2 staff are resident only required to but usually 2 staff are resident only required to but usually 2 staff are resident only required to but usually 2 staff are resident only required to but usually 2 staff are resident only required to but usually 2 staff are resident only required to but usually 2 staff are resident only required to but usually 2 staff are resident only required to but usually 2 staff are resident only required to but usually 2 staff are resident only required to but usually 2 staff are resident only required to but usually 2 staff are resident only required to but usually 2 staff are resident only required to but usually 2 staff are resident only required to but usually 2 staff are resident only required to but usually 2 staff are resident onl	nation's/ soothing words/ from the cares." /2/14, which had been ntified R44, "had movement] and was rning] care's. Was hitting olding onto her hand's to g into BM and striking out s were noted. Resident nd Assessment/ Monitoring tified R44 had left wrist cm x 5.2 cm and right g 3.6 cm x 2.8 cm. The ne specific intervention's o calm and reapproach ve." There was no rker had reviewed R44's g combative with care's. I dated 3/14/14, which had 4, identified, "When NA e assisting resident with led resident to have 2 rm. Author observed le in color measuring 6 cm n. NOC [night] nurse very combative during with her hands and arms. I resident's e was no indication the wed R44's bruising related in cares. 5/14, at 9:35 a.m. NA-D e with staff when they are esident. NA-D stated the one staff assist with cares, equired to help so one ent's hands down when NA-D stated she knows	F	The care plans of the afresidents 44, 50, 34 and with the 4 other reside were determined to be had their care plans revand updated on 4/16/1 include a more focused plan". This plan has respecific interventions for direct care staff to use the resident displays a behaviors. The facility worker has reviewed a input into additional interventions for the behaviors.  Skin audits were starte week of 4/21/14 for the residents above which 3 times a week for 60 remaining residents in will have weekly skin a for 60 days to assure the residents are being mount on the residents are also and the residents are also are also and the r	d 53 along ints which at risk viewed 4 to 4 to 4 to 5 dident for the when/if ggressive social and offered behavior days. The athe facility audits done that all conitored for 8 residents ermined to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
	245465	B. WING_		04/17/2014
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZII 410 WEST MAIN STREET OSAKIS, MN 56360	PCODE
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLETION DATE
staff were trying to gresidents are so resiget the resident's capossible." NA-D staresident's had deve them down to perform they are just so framuch when we are habout a month ago brief changed and we staff had to hold the the resident could be about 2-3 hours late wrists had bruising NA-D stated that make wiew of R44's property occasions. There we assessment done be interventions were implemented, or to receiving injury from combative.  During interview on worker (SW)-A state bruising occurring from was not aware of the combativeness with R50's admission Make the resident had serequired extensive rejected care 4-6 deseases attempting to propose the combative or stated R50 is combis attempting to propose the combativ	om holding them down when get cares done, but, "The sistive and staff is just trying to ares done as quickly as ated she felt "horrible" when loped bruising from holding rm cares, but she stated, agile and struggling with us so holding them." NA-D stated "R44 needed to have her was resistive. NA-D stated er resident's wrists/ hands so be cleaned up. NA-D stated er "staff" observed R44's on "like perfect hand prints." adde her feel "horrible." obgress notes from 10/3/14 to he resident was identified as with cares 18 different was no follow up or by the social worker to ensure appropriate, being ensure the resident was not m staff as a result from being an 4/17/14, at 1:35 p.m. social ed she was not aware of the from staff restraining R44 and the frequency of R44's and the frequency of R44's and the staff during cares.  DS dated 2/18/14, identified evere cognitive impairment, assistance with all ADLs, and anys of the 7 look back	F 2	audited twice week cares to monitor the staff and resident in while cares are being These audits will conveekly for 30 days and then weekly for 30 days. Any newer injuries will be reprimmediately to the and a Vulnerable of filed to OHFC.  The following system have taken place of the incident included interventions. All IDT will review and the incident included incident included incident included incident	nteraction ng provided. continue twice from 4/21/14 or the following unexplainable orted e administrator Adult will be  em changes since 4/16/14- estigative form d implemented i includes a dent, interview and care plan members of the d sign off on ding the orker and inday through by an RN. On ident

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245465	B. WING _			04/17/2014	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT 410 WEST MAIN STRE OSAKIS, MN 56360	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CO	DER'S PLAN OF CORRECTION PRRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRI DEFICIENCY)	E (X5) COMPLETION ATE DATE	
F 250	requires 2 staff, one to hold the resident's be provided. NA-A s behavior to the nurse know what the nurse the resident's behavi verified she had not liverified she had liverified s	to provide the cares, and one hands and feet so cares can tated she reports R50's e "everyday," but does not does with the information as or never improves. NA-A peen talked to by the social 0's behaviors. ated 4/14/14, identified the ewith cares, wanders, verbal ne with cares, and may it other's who propel in her ons included allow time for an providing cares, keep her and attempt to distract with unipulate her hand's. It was asked to provide from January 1, 2014 to tated R50 had no injury	F	include the Mood/Beh Procedure the DON o the addition "behaviors worker will review and intervention these care meetings, residents a conference monthly R worker was quarterly assessmen nursing st review the behaviors intervention the social be able to	was updated to ese revisions. The navior Policy and was also updated by a 4/16/14 to include on of individualized plans" which will be lace if a resident is a ry related to aggres. The facility social libe involved in the development of the ons put into place in explans during daily I will review with and families during eas and also during Risk meetings. The seas unaware that a mood and behavior int was completed by eaff. These assessments and current care plains. Moving forward worker will review of add input and will mood/behavior	t sive  e DT care ocial / nts s' an d, and	

PRINTED: 05/06/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245465	B. WING			04/	17/2014
	ROVIDER OR SUPPLIER		<u></u>	41	REET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET SAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 250	get done." NA-D statcharge nurse "all the done to help caring for stated, "I know it isn't down], but how else of Review of R50's prog 4/13/14, identified the "combative" with care. There was no further review done by the so interventions were aport to ensure the resid from staff as a result cares.  During interview on a stated she was not avoccurring from staff reaware of the frequency with staff during care.  R34's quarterly MDS resident had moderate required extensive as rejected care 1-3 day assessment period.  During interview on a stated R34 is combat stated staff will some resident later to provi work they will need to with holding the resident later to provide the cares. LIR34's arms and legs cares done on R34.  R34's care plan date resident is verbally a cares. The intervent	s done or they would never ed she reports this to the time" but nothing is ever or R50 any easier. NA-D right [to hold residents to you do cares?" ress notes from 2/12/14 to exercise the second of t	F	250	assessments. The social work will also bring the results of the mood/behavior assessment was to the quarterly care conferent to discuss any issues and care plan interventions with the resident and family. The social worker will use this as a tool when completing her CAA's of the MDS. Any discrepancies is notes, or if any changes need be made to the residents' placare will be reviewed with the IDT team and passed down to direct care staff. The social worker completes a social his upon admission. Any information that could be used to assist with decreasing potential behavior will be added to that resident care plan. On 4/17/14 the December 19 Administrator and LSW reviet the facility Vulnerable Adult Policy and Procedure and multiple changes which inclusives the addition of reference changes in the policy and places upon the policy estimates and the suspension for employees upon the policy and places upon the policy estimates and the policy and places upon the policy estimates and the policy and places upon the policy estimates and the policy and places upon the policy estimates and the policy and places upon the policy estimates and the policy and places upon the policy estimates and the policy and places upon the policy estimates and the policy and places upon the places up	ne vith nce al n he to n of e o the story ation vith ors ts ON, ewed ade ude ecks, nder	

Facility ID: 00109

	DF OEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245465	B. WING			04/	17/2014
	ROVIDER OR SUPPLIER			41	REET ADDRESS, CITY, STATE, ZIP CODE O WEST MAIN STREET SAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 250	when behavior is exh communication is ma understand's what is behavior with residen leave situation until b later; "Verbally demail On 4/14/14, the facilit reports from January DON stated injury report was dated 1/20/14. The rhave bruising to bilate had increased physic cares, including hittin with fists, bare hands transfers." The imme "Monitor bruising until approach when angrefurther investigation of social worker review being provided. Review of R34's wouthe following: 12/28/13- Right foreat Right forearm bruising [depth]. The monitor bruising was dark puindication the social worker indication the social worker hand [back] meas appearance indicated multiple to left arm. It in color. Discontinue Resident may be bur 1/11/14- Right forearm	and effect relationship libited, assure good intained and resident happening, set limits for t. If non-compliant and safe, ehavior stops. Reapproach and behavior stop."  y provided R34 injury  1, 2014 to present. The ports prior to January 1,	F.	250	new employees with a focus of Alzheimer's/dementia care, so burnout, and supportive care the residents during pending investigation of an incident. As staff are aware that all incide need to be thoroughly investigated to find root causs and to assure that the investigation component is complete. If abuse has been suspected, a Vulnerable Adult report will be submitted immediately.  Risk meetings will be held monthly starting in May 2014 and will have a focus on reviewing incidents/accident and individual resident care to address behavior plans are interventions. The social wo will be present and offer input hese meetings. This meetin continue indefinitely and the trends developed by this team will be brought forth and discussed during the facility	taff of All nts te taff taff of all nts te taff taff taff taff taff taff taff t	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245465	B. WING			04	/17/2014
	ROVIDER OR SUPPLIER			41	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET ISAKIS, MN 56360	·,	-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 250	fading in the middle. bruise." There is no fi explanation of the bru 1/20/14- Left back har bruising. "Has one pet the left hand and has her forearm." There is explanation of the bru During interview on 4/stated R34 is often costated it will often take cares because one had the other staff is proving stated R34 is very concares because she do of her.  Review of R34's programmer of the being "combative" with occasions. There was assessment, or invest worker to ensure interbeing implement, or to not receiving injury fro being combative during During interview on 4/stated she was not aw occurring from staff renot aware of the frequic combativeness with st R53's annual MDS dat resident had moderate required extensive asseriected care 1-3 days assessment period. During interview on 4/stated productive on 4/stated she was not aw occurring from staff renot aware of the frequic combativeness with st R53's annual MDS dat resident had moderate required extensive asseriected care 1-3 days assessment period.	Yellow color to middle of urther investigation or ising.  Ind bruising and left arm enny sized bruise present on multiple bruises present on no further investigation or ising.  15/14, at 9:05 a.m. NA-A mbative with cares. NA-A e "a few of us" to provide us to hold her hands while ding the cares." NA-A mbative when males provide esn't like men to take care ess notes from 12/25/13 to resident as identified as a cares on 13 different is no further follow up, igation done by the social ventions were appropriate, a ensure the resident was m staff as a result from g cares.  17/14, at 1:35 p.m. SW-A hare of the bruising estraining R34, and she was ency of R34's aff during cares.  16d 1/9/14, identified the ecognitive impairment, instance with ADL, and of the 7 day look back	F	250	QA&A meetings which the factorial worker also attends.  The corrective action for F250 was completed on 5/16/14	·	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		TE SURVEY MPLETED
		245465	B. WING _		0	4/17/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 410 WEST MAIN STREET OSAKIS, MN 56360	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 250	provide cares. R53's plan of care daresident hollers and y attention, or for no re redirectable" The i resident why he is ye if not cooperative use On 4/14/14, the facilireports from January DON stated injury regother facility provided dated 3/2/14, with a rewhich identified the resident of the facility provided dated 3/2/14, with a rewhich identified the resident of the facility provided dated 3/2/14, with a rewhich identified the resident of the facility provided dated 3/2/14, with a rewhich identified the resident of the facility provided dated 3/2/14, with a rewhich identified the resident of the facility provided dated 3/2/14, with a rewhich if the facility provided dated 3/2/14, with a rewhich if he facility provided dated 3/2/14, and be wound Assessment identified R53 had (2 measuring 1.3 cm x (3 measuring 1.3 cm x (3 measuring 1.3 cm x (4 measuring 1.3 cm x (4 measuring 1.3 cm x (4 measuring interview on 4 measuring inter	resident's arms down to  ted 4/14/14, identified the rells if "painful, want's asonnot always ntervention's include ask the lling, is a 1 assist of staff, but a 2 staff. by provided R53's injury 1, 2014, to present. The borts prior to January 1, l. one injury report for R53 revision date of 4/14/14, resident was "Combative with ng arms in PAL. Abrasion or HS cares completed and Monitoring Report left antecubital abrasion(s) 0.7 cm and 1 cm x 0.3 cm. red were, "Check for any 1/15/13, at 9:35 a.m. NA-D boative with cares and "just y to do something with him." for can usually "Handle him," restaff tries to walk away and restart restart will need to hands/ legs] to do care's. what we have to do" to gress notes from 12/1/13 to	F2	250		

	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BUILDI	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		245465	B. WING			04/17/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 410 WEST MAIN STREET OSAKIS, MN 56360	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 250	or to ensure the reside from staff as a result cares.  During interview on 4 stated if a resident was would ensure the bruensure healing. LPN staff needed to hold oprovide cares and waresulted from staff resistated she did not this investigation or report the bruising was related she was aware combative.  During interview on 4 stated she was aware combative residents stated if a resident is cares, staff should lear eapproach. DON stadone for these reside residents who are differesidents who are differesident has dementimally be resistive with "care's done as quick residents you can't jubrief and not get care "There is a point we know that residents a staff was restraining to make sure the resion injuring themselve reports of bruising was related to "combative bruising was not susfull investigation becaresidents weren't bei	ent was not receiving injury from being combative during //15/14, at 8:50 a.m. LPN-C as noted with bruising she ising was monitored to -C stated she was aware combative resident's down to	F	250		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(XS	3) DATE SURVEY COMPLETED
		245465	B. WING			04/17/2014
	ROVIDER OR SUPPLIER  TY MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360	:	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 250 F 280 SS=D	cares to ensure indivi in place. The DON venot involved in investito be reported to the stated she was not avoccurring from staff re R34, and R53 when p in the daily morning mase managers, and the bruising or specific be about. SW-A stated stresident had combaticares performed bruising because they all known verified the bruising were residents who assessing residents who assessing residents who are contacted to the facility was asked policy/ procedure on the facility was asked to the fac	aviors or combative with dualized interventions were erified the social worker was gations unless they needed state agency.  2/17/14, at 1:35 p.m. SW-A vare of the bruising estraining R44, R50, roviding cares. SW-A stated neeting held with herself, RN the DON, residents with discussed, but specific thavior's were not talked she would just "assume" if a ve behavior's when having sing happened because would bruise." SW-A stated of "Our staff" of any abuse veach other so well. SW-A vas not investigated, nor were combative with cares sed to ensure appropriate place. SW-A stated, "We lem [investigating and who are combative with se better." SW-A stated she d in any investigating or sing related to cares, but going forward she se involved.  If but did not provide a the facility social worker sing and investigating mbative with care.  It is a social worker sing and investigating mbative with care.  It is a social worker sing and investigating mbative with care.  It is a social worker sing and investigating mbative with care.  It is a social worker sing and investigating mbative with care.  It is a social worker sing and investigating mbative with care.  It is a social worker sing and investigating mbative with care.  It is a social worker sing and investigating mbative with care.  It is a social worker sing and investigating mbative with care.  It is a social worker sing and investigating mbative with care.	F 2			
	The resident has the	right, unless adjudged				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE COMP	SURVÉY LETED
		245465	B. WING_	-		17/2014
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 410 WEST MAIN STREET OSAKIS, MN 56360	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 280	incompetent or other incapacitated under participate in plannir changes in care and  A comprehensive ca within 7 days after th comprehensive asse interdisciplinary tear physician, a register for the resident, and disciplines as determing and, to the extent profile the resident, the resident, the resident incomprehensive.	wise found to be the laws of the State, to g care and treatment or treatment. re plan must be developed	F 2	Resident 29 had first skin a survey on 4/16/14 and no noted. Resident 29's plan reviewed and updated on was changed from prn to sis to wear the elbow proteduring the day. Dermasave were ordered and placed of 5/16/14 to decrease incide Care plan was also update changes. IDT suggested us shin protectors as well relations.	audit done week of new injuries were of care was 4/24/14. Care plan state that resident ectors at all times er arm sleeves on resident on ents of bruising. In do include these are of Dermasaver atted history of	
	each assessment.  This REQUIREMENt by: Based on observation review, the facility for plan of care for 1 of experienced repeate lift.  Findings include: R29's current diagnoquarterly Minimum 12/06/14, included pand anxiety. The Micognitive impairments whort-term memory	on, interview and document ailed to review and revise the 4 residents (R29) who ad injuries from the standing coses, according to the Data Set (MDS) dated sychotic disorder, dementia DS also revealed significant at, with both long and		were ordered on 5/16/14 initiated once arrival to far Care audits have been in presidents since 4/21/14. Tincluded watching cares athe mechanical lifs. Upon it was determined that lice conduct transfer audits or currently in house using a device by 6/6/14. Any safe during the transfer will resimmediate review by the libe requested from Occup. Transfer audits will contin week of 6/9/14 and will codays. The audits will consitransfer of 10 residents at that all interventions asso	and will be cility.  place on behavioral hese audits and transfers with review on 6/3/14, ensed staff will also a fall residents mechanical lifting ety issues noted sult in an RN and input will ational therapy. The sue weekly starting continue for 60 ist of auditing the week to assure	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE  A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245465	B. WING		04/17/2014	
	ROVIDER OR SUPPLIER ITY MEMORIAL HOM	E	41	REET ADDRESS, CITY, STATE, ZIP CODE O WEST MAIN STREET SAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE   COMPLETION	
F 280	revealed 19 assessinjuries to the fore wound assessment whether the open continued measur wound assessment cause of the abraic R29's care plan, or mood as unpredict physically aggressicare plan identified elbow protectors injuries. Despite no other care plan injury were listed.  Review of facility were two reports standing lift as a lancident report for abrasion to the lebedtime. Resident he PAL (standing linder line line line line line line line line	ssments completed for abrasion head, arms and shins. The intreports did not indicate areas were new sites or rements of a prior injury. The intreports did not identify the sions.  Idated 6/19/12, identified R29's stable and the resident could be sive with cares. In addition, the identified to prevent arm insultiple abrasion areas noted, in interventions to prevent skin incident reports revealed there for R29 which identified the potential source of injury: or 1/19/14, identified a small fit forearm after toileting at the may have bumped her arm on a lift).  or 2/19/14, revealed while staff it to the bathroom via PAL, aviors and bumped back of left me, obtained laceration. Area	F 280	transfer of each resident are in place that staff are following each resident plan to maintain safety during the tr. The interventions will be reviewed q and prn with resident changes to assall interventions in the residents care remain appropriate to maintain the residents' safety.  The following system changes have to place since 4/16/14- A new facility investigative form was developed and implemented which includes a review incident, interview of staff involved, of current care plan interventions and discussion of whether changes to call interventions should be made. All most the IDT review and sign off on the including the facility administrator of through Friday and daily by an RN. To follow Vulnerable adult policy and pand the administrator is notified immediately of any incidents which reportable to OHFC.  If a resident obtains injury from a material transferring device, licensed staff work care plan and complete investigation assure that care plan was being followed that the care pla	ts care ansfers. uarterly sure that e plan  taken  ad w of the review ad re plan embers incident  Monday The staff procedure are are acchanical ill review an to owed. If to be mediately staff to The IDT sure that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI			(X3) DATE SURVEY COMPLETED	
		245465	B. WING_			04	1/17/2014
	ROVIDER OR SUPPLIER			41	REET ADDRESS, CITY, STATE, ZIP CODE O WEST MAIN STREET SAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280	her elbows on the bindicated these injurt twice per week.  During an interview NA-C said R29 was that "you never known and returned to standing lift by NA-Hwere not observed or room and returned which were new and were placed on R29 back to the wheelch Elbow protectors have resident's bedroom  An observation of Noff the toilet on 4/17 completed. A standused and R29 appeoutwards. NA-C melbows to get R29 the going through the bound and the power of the power	side outward and bumped athroom door frame. NA-A ries happened at least once or on 4/17/14, at 9:29 a.m., unpredictable with cares and w what may happen."  6/17/14, at 9:38 a.m. of R29 the toilet with the use of a rie and NA-C. Elbow protectors on the resident. NA-C left the with a pair of elbow pads, distill in the wrappers. They and she was then assisted thair with the standing lift. and not been observed in the for use prior to this time.  6/14. At 1:28 p.m. was standing lift was observed being that are to bow her elbows than all years and them inward while athroom door frame.  6/17/14, at 1:34 p.m.  7/14. At 1:34 p.m.  8/17/14, at 1:34 p.m.  8/17/14, at 1:34 p.m.  19/17/14, at approximately the of nursing (DON) indicated	F2	280	mechanical transfer device. A referr Occupational Therapy will be made needs more input or resources to me the residents' safety during transfer. Risk meetings will be held monthly in May 2014, and will have a focus or reviewing incidents/accidents and it resident care plans. This team will a interventions to keep the resident injury. This meeting will continue indefinitely. Any noted trends will be thoroughly reviewed by the team a brought forth and discussed during facility's QA&A meetings.  The corrective action for F280 was completed on 6/3/14.	if the IDT naintain rs. starting on ndividual address free from the ndividual address free from the ndividual address free from the nd	
	that it might be diffi	e director of nursing (DON) indicated be difficult for staff to apply the elbow ince the resident was already in the lift					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245465	B. WING_			04/	17/2014	
NAME OF PI	ROVIDER OR SUPPLIER			S7	REET ADDRESS, CITY, STATE, ZIP CODE			
COMMUN	TY MEMORIAL HOME	≣			O WEST MAIN STREET SAKIS, MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 280	Continued From pa	age 69	F 282 Plan of correction 6/3/14				1	
	and agreed the care plan may need to be revised with regard to how often the elbow protectors should be worn. The DON stated she typically reviewed incident reports Monday through Friday when she was in the facility and attempts to institute new care plan interventions.  The facility policy entitled Resident Incident/Accidents, last reviewed 4/16/14, directed the care plan to be updated as needed after incidents including injuries of unknown origin. The policy also directed licensed staff to immediately conduct an investigation into the				Resident 14 had skin audit done on 4/2 new injuries were noted. The new incident investigation form was used and review IDT at that time. Bruising root cause will identified and resident denied staff ha	dent wed with as rm. IDT		
					suggested use of Dermasaver shin prot replace sheepskin as well related histo lower extremity bruising and injury. Th ordered on 5/16/14 and will be initiate arrival to facility.	ry of lese were		
F 282 SS=D	cause of the accident or incident. 483.20(k)(3)(ii) SERVICES BY QUALIFIED		F:	282	Care audits have been in place on behavesidents since 4/21/14. These audits i watching cares and transfers with the mechanical lifs. Upon review on 6/3/14 determined that licensed staff will also transfer audits on all residents current	ncluded 4, it was conduct ly in house		
	This REQUIREME by: Based on observa review, the facility protective measure bruising in accorda of 4 residents (R14			using a mechanical lifting device by 6/6 safety issues noted during the transfer in an immediate review by the RN and be requested from Occupational thera Transfer audits will continue weekly staweek of 6/9/14 and will continue for 6 The audits will consist of auditing the t	will result input will py. arting 0 days.			
	1/16/14, included dementia. R14's s	nimum Data Set (MDS) dated diagnosis of aphasia and skin assessment, dated 4/7/14, not have any bruising.			10 residents a week to assure that all interventions associated with the trans each resident are in place and that staff following each residents care plan to make safety during the transfers. The intervention will be reviewed quarterly and promitted thanges to assure that all interventions.	ff are naintain entions n resident		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245465	B. WING			04/17/2014		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360		10 WEST MAIN STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			Œ	(X5) COMPLETION DATE	
F 282	skin between her shin to prevent skin injurie R14's wound assessmonths, January 201 incidents of abrasions planned intervention of for the staff to use pawas used to prevent An observation on 4/7 nursing assistant (NA bathroom using a sta Sheepskin was not of shins and the lift, the against the leg rests.  During an interview of family member (FM)-facility every Tuesday no sheepskin in the reprotect her legs in the didn't know "where the some people use it at FM-A pointed out bruwere brown in color at location her legs wou when the standing lift NA-C was observed of transferring R14 backgrown.	plan, dated 1/27/14, re the resident had sheep is and the PAL (standing lift) is with transfers.  Inent for the previous three 4-April 2014, noted two is on her lower leg. The of these assessments were dding to the area, when a lift further injury.  (5/14, at 9:24 a.m. of )-B lifting R14 onto the inding lift was completed. Observed in front of R14's legs were pressed directly in 4/15/14, at 9:45 a.m., A reported she came to the rand was upset there was esident's room to be used to estanding lift. She said she at [sheep skin] went to, and other people don't." is on R14's shins, which and corresponded to the lid came in contact with, was used.  On 4/17/14, at 9:22 a.m. is from the toilet to her	F	282	residents care plan remain appropriate in maintain the residents' safety.  The following system changes have take since 4/16/14- A new facility investigative was developed and implemented which a review of the incident, interview of strainvolved, review of current care plan interventions and discussion of whether to care plan interventions should be made members of the IDT review and sign off incident including the facility administration staff follow Vulnerable adult policy and procedure and the administrator is note immediately of any incidents which are reportable to OHFC.  If a resident obtains injury from a mech transferring device, licensed staff will recare plan and complete investigation to that care plan was being followed. If changes will occur immediately and mato the direct care staff to prevent further incidents of injury. The IDT will also revincident to assure that the resident remains to use the mechanical transfer device.	n place ve form includes aff changes de. All on the itor. The fied anical eview assure anges or ese de knowler iew each hains safe A referral f the IDT	1	
	recliner chair using the standing lift. A piece of sheepskin was noted lying on the resident's bed. When NA-C was asked about the purpose of the sheepskin, she indicated she should use it to protect R14's legs when being moved with the lift, however, she "forgot to use it." NA-C observed				needs more input or resources to maintain the residents' safety during transfers.  Risk meetings will be held monthly starting in May 2014, and will have a focus on reviewing			

PRINTED: 05/06/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING \_\_\_ 245465 B. WING 04/17/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 410 WEST MAIN STREET COMMUNITY MEMORIAL HOME **OSAKIS, MN 56360** PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLÉTION DATE (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIT NCY) incidents/accidents ah'd individual resident care plans. This team will address interventions to F 282 F 282 Continued From page 71 keep the resident free from injury. This meeting R14's bilateral shins and confirmed bruises were present, and stated she would go tell the nurse. will continue indefinitely. Any noted trends will be thoroughly reviewed by the team and The most recent progress note, completed on brought forth and discussed during the facility's 4/14/14, did not identify any bruising incidents. QA&A meetings. The facility policy related to skin care entitled The corrective action for F282 was completed on Community Memorial Home Wound Treatment Protocol, dated 7/11/05, did not provide specific 6/3/14. direction with regard to prevention of bruising or abrasion-type injuries. F 309 483.25 PROVIDE CARE/SERVICES FOR F 309 HIGHEST WELL BEING SS=D 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 F309 Plan of correction 6/3/14 and plan of care. Resident 29 had first skin audit done week of survey on 4/16/14 and no new injuries were noted. Resident 29's plan of care was This REQUIREMENT is not met as evidenced reviewed and updated on 4/24/14. Care plan bv: Based on observation, interview, and document was changed from prn to state that resident review, the facility failed to ensure 2 of 3 residents is to wear the elbow protectors at all times (R14, R29), reviewed with bruising and skin during the day. Dermasaver arm sleeves injuries had individual assessments and were ordered and placed on resident on interventions in place to ensure 5/16/14 to decrease incidents of bruising. bruising/abrasions was prevented. Care plan was also updated to include these Findings include: changes. IDT suggested use of Dermasaver shin protectors as well related history of R14 was admitted to the facility on 1/18/08. lower extremity bruising and injury. These R14's most recent quarterly Minimum Data Set were ordered on 5/16/14 and will be (MDS), dated 1/16/14, revealed diagnoses of aphasia and dementia. R14's skin assessment, initiated once arrival to facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245465	B. WING		04/	17/2014
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		REET ADDRESS, CITY, STATE, ZIP CODE		
COMMUN	ITY MEMORIAL HOME		1 "	0 WEST MAIN STREET		
20,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			0	SAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 309	Continued From pag	e 72	F 309	Resident 14 had skin audit done o	n 4/24/14	
		ed she did not have any		and new injuries were noted. The	new	
	bruising.	•		incident investigation form was us	ed and	
				reviewed with IDT at that time. Br	uising root	
		are plan, dated 1/27/14,		cause was identified and resident	denied	
	1	t was to have sheep skin		staff harm. IDT suggested use of D	ermasaver	
	petween ner snins ar prevent skin injuries	nd the PAL (standing lift) to		shin protectors to replace sheepsl	kin as well	
	prevent skin injunes	with transfers,		related history of lower extremity	bruising	
	Review of R14's wou	and assessment and		and injury. These were ordered or	n 5/16/14	
		r the last three months		and will be initiated once arrival to	facility.	
		nts of abrasions on the lower				
	leg, with padding the lift listed as a specific intervention to be used to prevent further injury.			Care audits have been in place on	behavioral	
	Intervention to be us	ed to prevent further injury.		residents since 4/21/14. These au	dits	
	Observation on 4/15	/14, at 9:24 a.m., revealed		included watching cares and trans		
	nursing assistant (N/	A)-B lifting R14 into the		the mechanical lifs. Upon review o	on 6/3/14,	
	bathroom using a sta	anding lift. No sheepskin was		it was determined that licensed st		
		4's shins and the lift, the legs		conduct transfer audits on all resi	dents	
	were pressed directi	y against the leg rests.		currently in house using a mechar		
	During interview on	4/15/14, at 9:45 a.m., family		device by 6/6/14. Any safety issue	s noted	
	member (FM)-A stat	ed she came to the facility		during the transfer will result in a	n	
	every Tuesday and v	was upset there was no		immediate review by the RN and	nput will	
	sheepskin in the res	ident's room to be used to		be requested from Occupational t		
	protect her legs in th	e standing lift. She said she hat went to, some people use		Transfer audits will continue weel		
	and other people do	n't." FM-A showed surveyor		week of 6/9/14 and will continue		
	hruises on R14's shi	ns, which were brown in color		days. The audits will consist of au	diting the	
		the location her legs came		transfer of 10 residents a week to	assure	
	in contact to the star			that all interventions associated v	vith the	
				transfer of each resident are in pl	ace and	
	During observation of	on 4/17/14, at 9:22 a.m. NA-C		that staff are following each resid	ents care	
	transferred R14 bac	k from the toilet to her the standing lift. A piece of		plan to maintain safety during the	transfers.	
ı	sheenskin was note	d lying on the resident's bed.		The interventions will be reviewed	d quarterly	
Ī	When NA-C was as	ked about the purpose of the		and prn with resident changes to		
sheepskin, she stated she should be using it to			all interventions in the residents of			
	protect R14's legs w	then being moved with the lift,				
	however, she forgot	to use it. NA-C observed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245465	B, WING			04/	17/2014
	ROVIDER OR SUPPLIER			41	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET SAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 309	R14's bilateral shins a present, and stated s  The facility policy related Community Memorial Protocol, dated 7/11/0 direction with regard abrasion-type injuries  The nursing progress recent notation made address any bruising  R29 was admitted to R29's current diagnor recent quarterly MDS psychotic disorder, dim MDS also revealed s impairment, with both memory problems.  Review of R29's Incident reports 1/1 abrasion to the left for a communication of the left for a communic	and confirmed bruises were he would go tell the nurse.  Ited to skin care entitled Home Wound Treatment Do did not provide specific to prevention of bruising or anotes revealed a most on 4/14/14, that did not incidents.  Ithe facility on 2/05/13. Ithe facility on 2/05/13. Ithe facility on 2/05/14, included the mentia and anxiety. The ignificant cognitive in long and short-term	remain appropriate to maintain the residents' safety.  The following system changes have taker place since 4/16/14- A new facility investigative form was developed and implemented which includes a review of incident, interview of staff involved, revior for current care plan interventions and discussion of whether changes to care plinterventions should be made. All membors the IDT review and sign off on the including the facility administrator Mondon through Friday and daily by an RN. The staff of the identification of the administrator is notified immediately of any incidents which are reportable to OHFC.  If a resident obtains injury from a mechotransferring device, licensed staff will resident operations.		taken  nd ew of the l, review and are plan members he incident Monday The staff procedure h are mechanical will review ion to llowed. If		
	the PAL (standing lift -Incident report for 2/staff assisting resident resident with behavior hand on door frame, was steri-stripped.  R29's care plan, date mood was unpredicted aggressive with care identified that the resident for the standard s				changes or new interventions nee made, these changes will occur im and made known to the direct car prevent further incidents of injury will also review each incident to a the resident remains safe to use t mechanical transfer device. A refe Occupational Therapy will be made needs more input or resources to the residents' safety during transfer.	d to be mediately e staff to v. The IDT ssure that he erral to de if the IDT maintain	

PRINTED: 05/06/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \_\_\_\_ B. WING 04/17/2014 245465 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 410 WEST MAIN STREET COMMUNITY MEMORIAL HOME OSAKIS, MN 56360 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 309 | Continued From page 74 F 309 Observation on 4/15/14, at 9:11 a.m. revealed R29 being transferred onto the toilet by NA-B and Risk meetings will be held monthly starting NA-A. No elbow protectors were used during the in May 2014, and will have a focus on transfer. reviewing incidents/accidents and individual During interview on 4/15/14, at 9:22 a.m., NA-A resident care plans. This team will address stated R29 needed elbow protectors on because interventions to keep the resident free from she "chicken wings" in the standing lift, sticking injury. This meeting will continue her backside outward and bumps her elbows on indefinitely. Any noted trends will be the bathroom door frame. This happened at least thoroughly reviewed by the team and once or twice per week. brought forth and discussed during the During interview on 4/17/14, at 9:29 a.m. NA-C facility's QA&A meetings. said R29 was unpredictable with cares and that you never know what may happen. The corrective action for F309 was completed on 6/3/14. Observation on 4/17/14, at 9:38 a.m. revealed R29 being transferred to toilet using the standing lift by NA-H and NA-C. R29 was assisted onto the toilet with the standing lift and no elbow protectors were in use. NA-C went and obtained a pair of elbow pads which were new and still in the wrappers for use on R29 to assist her back to the wheelchair with the standing lift. No elbow protectors had been in the room available to be used. Observation on 4/17/14, at 1:28 p.m. revealed R29 was being assisted off of the toilet with the standing lift by NA-C and NA-H, R29 was observed to bow her elbows outwards and NA-C manually had to touch R29's elbows to get R29 to bend them in while going through the bathroom door frame. During interview on 4/17/14, at 1:34 p.m. registered nurse (RN)-A confirmed that R29's care plan said R29 should have arm protectors on as needed, and stated the aides just needed

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245465	B. WING			04	/17/2014
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309 F 490 SS=F	to "kind of tell" when sides. 75 EFFECTIVE ADMINISTRATION/R  A facility must be admenables it to use its refficiently to attain or practicable physical, it well-being of each resultable. This REQUIREMENT by:  Based on interview a facility administrator of failure related to the linvestigation, protectiviolations of potential effected 4 of 4 reside R53) which resulted it (IJ).  In addition, the administration of providing cares to resonable from providing such a nursing assistants. The ensure appropriate employees was compassistants in the sam NA-E, NA-C, NA-K, administrator's involving system to ensure respotential to affect 40 in the facility.  Findings included:  During an interview of	ESIDENT WELL-BEING  ministered in a manner that esources effectively and maintain the highest mental, and psychosocial sident.  is not met as evidenced and document review, the failed to address a systemic		490	Resident 44, 50, 34, and 53 were assessed for bruising on 4/16/14 which was not correlated to any documented incidents. No injurie were noted on residents 44 and 5 Bruising, not correlated with an incident was located on resident and 34 which were immediately for to OHFC after the facility administrator was updated.  Resident 16 had skin audit performed on 4/26/14 which did reveal any alterations in skin integrity or new injury. Resident for is alert and was interviewed by the DON shortly after incident on 3/11/14 prior to her transport to hospital. Resident had denied state abuse, but moving forward, a vulnerable adult will be filed for a fracture which is obtained during cares.	not 16 16 16 16	

OLIVILIY	O TON WEDICANE &	WEDICAID SERVICES	<del>, </del>		, <u>, , , , , , , , , , , , , , , , , , </u>	<u> </u>	1	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(×	(X3) DATE SURVEY COMPLETED	
		245465	B, WING				04/17/2014	
	ROVIDER OR SUPPLIER			41	REET ADDRESS, CITY, STATE, ZIP CODE 0 WEST MAIN STREET SAKIS, MN 56360			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 490	staff needed to restra complete personal caresident is combative should leave the reside DON stated, "The carthese residents and the who are difficult." She had dementia, there is resistive with cares at done as quickly as pour can't just leave the get cares done." DO we have to provide caresidents are held doneeded cares. DON residents for their ow residents were not structured the stated this bruising was docume residents as related to She stated this bruisid did not require a full if facility was aware when and knew the resident the DON verified the assessments on residents were combative with individualized intervethe facility have any if staff who were provided when they were combative with individualized intervethe facility have any if staff who were provided when they were combative with individualized intervethe facility have any if staff who were provided when they were combative with individualized intervethe facility have any if staff who were provided when they were combative with individualized intervethe facility have any if staff who were provided when they were combative with individualized intervethe facility have any if staff who were provided when they were combative with individualized intervethe facility have any if staff who were provided in the provided in the provided intervether facility have any if staff who were provided intervether facility have any if staff who were provided intervether facility have any if staff who were provided intervether facility have any if staff who were provided intervether facility have any if staff who were provided intervether facility have any if staff who were provided intervether facility have any if staff who were provided intervether facility have any if staff who were provided intervether facility have any if staff who were provided intervether facility have any if staff who were provided intervether facility have any if staff who were provided intervether facility have any if staff who were provided intervether facility have any if staff who were p	in combative residents to res. The DON stated if a or resistive with cares staff dent safe, and reapproach. The safe, and reapproach are have to get done for here are just some residents a risk the resident may be and staff needs to get "cares assible for these residents; are in a soiled brief and not are and I know that while by staff to provide the stated staff were restraining an safety to make sure the risking staff or injuring rified injury reports of at times for some or "combative with cares." In gwas not suspicious and investigation because the ere the bruising came from the weren't being abused. If acility did not complete dents with behaviors or who cares to ensure into were in place; nor did investigations or tracking of ling cares to the residents bettive with cares and ON verified the administrator ent/knowledge of the	F	490	All residents in the facility we discussed on 4/15/14 and 4/with both IDT which includes administrator and direct care and 4 other residents in the were determined to be at a risk of obtaining injury relate their combative and aggress behaviors. These 4 other reswere also assessed on 4/16/injuries which were not doct in an incident report. No new unexplained injuries were not their care plans of the affected residents 44, 50, 34 and 53 awith the 4 other residents were determined to be at rismelated to aggressive behavior their care plans reviewed an updated on 4/16/14 to include more focused "behavior plan plan has resident specific interventions for the direct of to use when/if the resident of aggressive behaviors.  The nursing assistant who had disqualified from DHS was suspended without pay on 4	d the e staff facility higher ed to ive idents (14 for umente wor oted. ed along hich sk ors had de a er". This care stadisplays	ed Inff	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED		
		245465	B. WING			04/17/2014	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI  REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 490	letter was found in the 2/27/14, referencing NA-D. The letter information employee had been that allowed direct opersons who receive regulatory agencies facility that it may characteristic persons who receive regulatory agencies facility that it may characteristic provide direct contain reconsideration decand if they chose the following:  Obtain from the notice of disqualificate reason for the disqualificate reason for the disqualificate of disqualificate.  Ensure the employee since of the person of t	the employee file, dated the background study for ormed the facility the disqualified from any position ontact with or access to ed services from state . The letter also informed the mose to allow the person to ct services pending a possible ision by the Commissioner is option they must do the employee a copy of the ation which explained the ralification; ployee requested hin 30 days of receiving the ation and; ployee was under continuous, when providing direct contact has receiving services from ling reconsideration of the  uman resources (HR)-A was 14, at 12:02 p.m. HR-A did t (NA-D) had been employed he initial Background Study and by the facility on 9/11/13, hate any problem with the or cares for residents. HR-A he disqualification letter around he he gave a copy of the letter corted he was unsure of what the OON) received the letter. He he open was still employed at the he ght NA-D was still providing	F	490	pending the appeal process and we terminated from employment with the facility on 4/24/14 upon the notification that the appeal had been denied and the employee we disqualified from providing service to persons receiving benefits from DHS.  As of 5/16/14, all nursing staff had been assigned two education sessions called "Abuse Prevention Persons with Dementia: The Basic and "Client Behaviors: Assessment and Intervention in the Resident with Dementia" from the online education system, "Healthcare Academy". The staff have until Jud 6th, 2014 to complete the required education courses until discipline enforced by administration.  The following system changes had taken place since 4/16/14- All state aware that they are mandate reporters. The administrator will notified immediately of any VA reportable incidents per the Vulnerable Adult Policy and Procedure on all days of the weel including weekends. A new facility investigative form was developed.	ch as es es n ve and the ed e is ve affined be	

NAME OF PROPUDER OR BUPPLIER  COMMUNITY MEMORIAL HOME  SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL RECOLLATION OF LISC IDENTIFYING INFORMATION)  FEAST MAIN STREET OSAKIS, MN 58360  F 490  Continued From page 78  An interview with the DON was completed on A/16/14 at 2:14 p.m. She reported she was not aware why the employee (NA-O) had been disqualification but the reason for the disqualification but the reason for the disqualification but the reason for the employee mailing information to the regulatory agency requesting reconsideration. The DON reported the disqualification. The DON down and the employee and sent home and did not return to work until after proof was contained of the employee mailing information to the regulatory agency requesting reconsideration of the disqualification. The poly more many than the request for reconsideration of the disqualification. The DON down and the requirements as the DON was completed on A/16/14 at 2:45 p.m. The DON reported for NA-D was allowed to return to work after she met the requirements as the DON was completed on A/16/14 at 2:45 p.m. The DON reported the requirements as the DON was completed on A/16/14 at 2:45 p.m. The DON reported the requirements as the DON was completed on A/16/14 at 2:45 p.m. The DON reported the requirements as the DON was allowed to return to work after she met the requirements as the DON was allowed to return to work after she met the requirements as the DON was allowed to return to work after she met the requirements as the DON was allowed to return to work after she met the requirements as the DON was allowed to return to work after she met the requirements as the DON was allowed to return to work after she met the requirements as the DON was allowed to return to work after she met the requirements as the DON was allowed to return to work after she met the requirements as the DON was allowed to return to work after she met the requirements as the DON was allowed to return to work after she met the requiremen	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
OMMUNITY MEMORIAL HOME  SIMMARY STATEMENT OF DEPICIENCIES (SAMES, MIN 5380)  FRETIX (SAME AND ALL AND		-	245465	B. WING		04/17/2014	
F 490  Continued From page 78 An interview with the DON was completed on 4/16/14 at 2:14 p.m. She reported she was not aware why the employee (NA-D) had been disqualification but the reason for the disqualification but the reason for the disqualification was not given. The DON reported the employee mailing information to the regulatory agency but had been to to work until after proof was obtained of the employee mailing information to the regulatory agency but had been to the disqualification. The employee with a letter of reference and a current job evaluation completed by the DON, which the DON indicated to work at the facility, under the supervision of a licensed practical nurse (LPN). A second interview with the DON was completed to 4/16/14 at 25 p.m. The DON reported the regulatory agency but had been told the employee dad been disqualification. The employee that he regulatory agency but had been told the employee dad been disqualified and had not been given a copy of the letter from the employee specifying the rationale for the disqualification. The DON asonowledged that N-D provided septicipation and not been given a copy of the letter from the employee specifying the rationale for the disqualification. The DON asonowledged that N-D-D provided septications are as to the disqualified and had not been given a copy of the letter from the employee specifying the rationale for the disqualification. The DON asonowledged that N-D-D provided septicipations are to the disqualification by DHS, training of new employees with			E		410 WEST MAIN STREET		
F 490  An interview with the DON was completed on 4/16/14 at 2:14 p.m. She reported she was not aware why the employee (NA-D) had been disqualified from providing care and services for the residents at the facility. She reported when she received the disqualification better she met with the employee (on approximately 2/27/14) and was told by NA-D, she had also received the letter of disqualification but the reason for the disqualification was not given. The DON reported the employee was sent home and did not return to work until after proof was obtained of the employee mailing information to the regulatory agency requesting reconsideration. The DON reported the edicity provided the employee with a letter of reference and a current job evaluation completed by the DON, which the DON indicated accompanied the request for reconsideration of the disqualification. The problem of the sequence with the DON and the DON and the DON indicated on 4/16/14 at 2:45 p.m. The DON reported NA-D was allowed to return to work after she met the requirements as the DON understood them. The DON was unable to recall who had informed her of this. The DON again stated she did not know why the employee had been disqualified and not been given a copy of the letter from the employee specifying the rationale for the disqualification. The DON acknowledged that NA-D provided services/personal cares to	PREFIX	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE COMPLETION	
doors. She acknowledged the licensed nurse on duty was to supervise the employee but acknowledged no special plan had been devised  a focat on Atzhelmic 3) dements care, staff burnout, and supportive care of the residents during pending	F 490	An interview with t 4/16/14 at 2:14 p.r. aware why the em disqualified from phe residents at the she received the cwith the employee and was told by N letter of disqualification was to work until after employee mailing agency requesting reported the facilit letter of reference completed by the accompanied the the disqualification to work at the facilit letter of reference completed by the accompanied the the disqualification to work at the faciliticensed practical A second interview on 4/16/14 at 2:45 NA-D was allowed the requirements. The DON reporter regulatory agency employee did not DON was unable of this. The DON why the employee not been given a employee specify disqualification. NA-D provided se residents, indeped doors. She acknowledges and the second interview of the second inte	he DON was completed on m. She reported she was not ployee (NA-D) had been providing care and services for the facility. She reported when the disqualification letter she met also proximately 2/27/14) A-D, she had also received the ation but the reason for the stand given. The DON reported as ent home and did not return proof was obtained of the information to the regulatory greconsideration. The DON y provided the employee with a and a current job evaluation DON, which the DON indicated request for reconsideration of the memory of the supervision of a nurse (LPN). We with the DON was completed to return to work after she met as the DON understood them. If the did not contact the power who had informed her again stated she did not know that had been disqualified and had copy of the letter from the ing the rationale for the the DON acknowledged that envices/personal cares to indently and behind closed only in the employee but	F 49	review of the incident, interstaff involved, and care plar interventions. All members IDT review and sign off on the incident including the facility administrator Monday through Friday and daily by an RN. A VA incidents will be reported immediately to the administration on 4/16/14, The Resident Incident/Accident Policy and Procedure was updated to ithese revisions. The Mood/Repolicy and Procedure was alluphated by the DON on 4/1 include the addition of indivibehavior plans" which will into place if a resident is at injury related to aggressive behaviors. On 4/17/14 the Resident in a divinistrator and LSW revisions. On 4/17/14 the Resident in a divinistrator and LSW revisions and made multiput changes which include the addition of reference checks, suspendently a focus on Alzheimer's/demicare, staff burnout, and supported to the staff burnout and the staff burnout.	view of nof the hee y ugh gain, any d crator.  d nclude Behavior so 6/14 to vidualized be put risk of DON, ewed the icy and ole addition sion for ion by yees with centia portive	

CENTER	3 TON MEDICANL &	MEDICAID SERVICES				AVAL DATE	CUDVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245465	B. WING			04	/17/2014
NAME OF D	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUFFLIER				WEST MAIN STREET		
COMMUN	ITY MEMORIAL HOME			OS	SAKIS, MN 56360		
<del></del>					PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	COMPLETION DATE
F 490	Continued From page 79		F	490	investigation of an incident. Or		
1 430		I supervision for NA-D.	'		4/17/14 the DON contacted al		
	An interview with the				licensed staff and informed the		
	completed on 4/16/1	4, at 3:05 p.m. During the			the changes in the Vulnerable	Adult	
	interview, NA-D repo	rted "had no idea why I was			Policy and Procedure and the		
	disqualified" and she had contacted Background Division but they would not tell her the rationale				revisions made to the		
	Over the phone NA-	D adamantly denied she was			Incident/Accident Policy and		
		ng the rationale for the			Procedure. A mandatory nursi	ng	
	disqualification. NA-D reported she needed to				staff meeting was held on 4/2		
	provide FBI fingerpri				and a review of the revised		
		om the DON, her direct of her coworkers in order for			incident/accident procedure v	/as	
	the agency to recons	sider the disqualification. She			reviewed. All staff are aware t		
	reported she obtaine	d these items and mailed			incidents need to be thorough		
	them on 3/7/14, and	provided a receipt of the			investigated to find root cause		
	allowed to return to	OON, after which she was work. She indicated she			to assure that the investigation		
		rvision of the LPN on duty			component is complete. If abo		
	and used the buddy	system with the two other			been suspected, a Vulnerable		
	staff that she worked	with. NA-D indicated the				Addit	
	"buddy system" mer	ant the nursing assistants residents they were assigned			report will be submitted		
	to and that she did n	ot need "a babysitter," She			immediately.		
	reported she could a	and did independently care for			The administrator and DON ha	ve	
	residents, with no sp	pecial limitations. She verified			been meeting daily when able	since	
	it was acceptable for	r her to independently provide n their rooms with door closed			4/22/14 during the work week	to	
	and she was under	no special supervision.			review and discuss the ongoing		
					audits, trends, cares, and incid		
	An interview with the	administrator was			and daily happenings at the nu		
	completed on 4/16/14, at 3:15 p.m. He acknowledged he was aware of the disqualification letter related to NA-D. He also acknowledged he was aware she had returned to the facility and was working with residents independently, while waiting for a decision related to the reconsideration of the disqualification. He reported the DON had discussed the situation with him related to the disqualification of NA-D				home. The administrator has b		
					keeping a log of these meeting		
					keehing a log of these meeting	,	
					Risk meetings will be held mor	nthly	
					starting in May 2014, and will		
					focus on reviewing		
					locas off feviewing	ا الله	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	CONSTRUCTION	COMPLETED		
		245465	B. WING		04/17/2014		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 410 WEST MAIN STREET OSAKIS, MN 56360				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL! CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION		
F 490	employee to return to process. When aske "continuous direct suprespond.  Reference checks The facility failed to opersonal references fin the sample (NA-I, NA-K, & NA-L) who had interview with the 4/17/14 at 9:20 a.m. responsible to check references and shoul employee they were unable to provide evireferences had been  No indication was give administrator during the expectations of such Quality Assurance  An interview on 4/17, completed with the DASSURANCE Committee a member. The DON the number of incider committee, however, discussed. The DON Assurance Committee questioned" the numinjuries, or the nature administrator did not	the decision to allow the work during the appeal and as to the definition of pervision," he did not wheck professional or for 7 of 10 nursing assistants NA-J, NA-D, NA-E, NA-C, and direct resident contact.  DON was completed on She reported she was potential employee's dhave done this for the any considering hiring. She was dence that these employees' checked.  If the hiring process or his which are shared with the specific incidents are not and indicated the Quality	F 490	incidents/accidents and individents resident care plans to address behavior plans and intervention. The administrator will attend the mtg and if unable to attend, administrator will be given versummary of the mtg. This meet will continue indefinitely and the trends developed by this team be brought forth and discussed during the facility's QA&A meet The DON will also start to bring facility incident reports with the QA&A meetings. This will allow review of the incident and investigation, including staff interviews and conclusion of recause to be discussed and review by the QA&A members.  Corrective action for F490 was completed on 5/16/14	chis  chal  che  n will  d  etings. g the to the  w  coot iewed		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	COMPLETED	
		245465	B. WING	04/17/2014	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME			4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DSAKIS, MN 56360	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			
F 520 F 520 SS=F	assurance committee nursing services; a p facility; and at least 3 facility's staff.  The quality assessment committee meets at 1 issues with respect to and assurance activity develops and implement action to correct identical content of the recept insofar as succompliance of such compliance of such compliance of this.  Good faith attempts and correct quality do a basis for sanctions.	in a quality assessment and a consisting of the director of hysician designated by the other members of the  ent and assurance east quarterly to identify by which quality assessment ties are necessary; and ments appropriate plans of tified quality deficiencies.  Itary may not require ords of such committee ords of such committee ords of such the committee with the section.  By the committee to identify efficiencies will not be used as	F 520 F 520	F520 Plan of correction on 5/16/14	e or, who itor of rently an of otential ention w and all in with cient These or and dit to our our or IDT
	by: Based on interview facility's Quality Asse (QA&A) committee for concerns related to read unknown origin ar	T is not met as evidenced and document review, the essment and Assurance ailed to identify quality resident injuries and bruising and potential staff abuse. This effect 40 of 40 residents the facility.		appropriate staff interventions, and re procedures concerning employee background and reference checks. In addition, the QA & A committee will reall incidents, investigations, and trend any, for consideration in their develop and implementation of additional and	evised eview s, if ment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE COMP	SURVEY LETED
		245465	B. WING			04/	17/2014
	ROVIDER OR SUPPLIER	240400		ST 41	REET ADDRESS, CITY, STATE, ZIP CODE 0 WEST MAIN STREET SAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 520	enforce a resident enform physical abuse R50, R34, R53) who behaviors. The failure combative residents monitored to ensure were in place and be and the lack of inves who identified restrai providing cares whice residents, resulted in on 4/15/14, at 4:47 p53 who were identified were combative with restrain them.  Refer to F225/F226 resident injuries and origin and potential sinvestigated and repstate agency for 5 of R53, and R16) who unknown origin, pote injury resulting from facility Vulnerable Active Prevention Plan lack the resident during a be supervised during and identifying staff deal with resident agreference checks or employment.	facility failed to promote and vironment that was free for 4 of 4 residents, (R44, exhibited combative e of the facility to ensure were assessed and appropriate interventions ing implemented by staff, tigation and oversight of staff ning residents while he resulted in bruising to the an immediate jeopardy (IJ) a.m. for R44, R50, R34, and ed by staff as residents who cares which required staff to as the facility failed to ensure injuries/bruising of unknown staff abuse were thoroughly orted to the administrator and a foresidents, (R44, R50, R34, experienced injuries of ential staff abuse, and/or staff providing cares. The dult Policy and Procedure/ked instruction on protecting an investigation, how staff will g an investigation, definition burnout, training on how to agression, and obtaining a employees before beginning	F	520	appropriate plans of action to considentified quality deficiencies. And monitoring from the QA & A will continue indefinitely. In fut of the QA & A Committee, the Coordinator/Administrator will a concerns about quality from eact committee member representing spectrum of services provided to Memorial Home residents. Folloquality improvement plans that developed by or at the request Committee will be monitored for effectiveness by the Coordinator reported at all subsequent QA & meetings. The next QA & A meetings. The next QA & A meetings been tentatively scheduled for The corrective action for F520 completed on 5/16/14	Oversight A Committee ure meetings solicit ch and every ng the full o Community ow-up on have been of the QA & A or or and & A eting has 6-17-14.	
	During an interview DON indicated the 0	on 4/17/14, at 3:52 p.m., QA&A meetings are held			acility ID: 00109	If continuation sh	eet Page 83 of 8

PRINTED: 05/06/2014 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	COMPLETED	
		245465	B. WING		04/17/2014	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME			4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 520	quarterly. DON indic number of incidents the committee, how not discussed. DON committee has "nev	ge 83 cated she makes a list of the and falls which is shared with ever, specific incidents are I indicated the QA&A er really questioned" the and injuries, or the nature of	F 520			

#### The following is an addendum for the Community Memorial Home Plan of Correction for 6/3/14

Please add the following additions to the correlating deficiency tags:

F223, F226- The Care and Skin audits on residents are completed by licensed staff. The Case Managers place new audit forms in the audit books for the LPN's and RN supervisors to complete for the week. The director of nursing follows up to assure that these audits have been completed each week. The Director of Nursing is auditing all incident reports to assure that the correlating new incident/investigation form which was recently developed is completed and attached to the incident. The administrator is also auditing these forms to assure staff are in compliance with the corrections and system changes that have been made.

F225, F226-The administrator is auditing the Director of Nursing to assure that all bruising or incidents have been thoroughly investigated and reported to required entities per Vulnerable Adult Policy and Procedure. The administrator reviews all incidents and signs off to assure that they have been investigated as well. The department heads complete reference checks prior to new hire employment on the staff in their department. The business office receives the information along with the employee application to gather new hire paperwork and enter that individual into the facility staff system. The business office, particularly "Payroll/Accounts Payable" employee will audit the new hire application to assure that a reference check has been completed prior to starting.

F250- The administrator oversees and will audit Social Services to ensure that social worker is providing required services to all residents in the facility. The administrator will meet with the facility social worker daily as able to review and assure that said corrections for F250 have been followed through on.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

F5465023

PRINTED: 05/06/2014 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 02 - 2 BLDG PT/OT WELLNESS CENTER 245465 B. WING 04/16/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 410 WEST MAIN STREET . COMMUNITY MEMORIAL HOME **OSAKIS, MN 56360** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY)

K 000 INITIAL COMMENTS

K 000

FIRE SAFETY

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, the 2008 Wellness Center Addition of Community Memorial Home was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC),

Chapter 18 New Health Care.

Community Memorial Home was surveyed as two separate buildings. The 2008 Wellness Center addition is a 2-story building with no basement, and was determined to be of Type II (111) construction.

The building is fully fire sprinklered throughout and has a fire alarm system that includes smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.

The requirement at 42 CFR, Subpart 483.70(a) is MET.

\$ 5-29-14



LABORATORY DIRECTOR'S OR PROVIDENSUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

Event ID: 5L8E21

Facility ID: 00109

If continuation sheet Page 1 of 1

PRINTED: 05/06/2014 FORM APPROVED

OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 245465 04/16/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 410 WEST MAIN STREET COMMUNITY MEMORIAL HOME **OSAKIS, MN 56360** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION (FACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) **INITIAL COMMENTS** K 000 K 000 FIRE SAFETY K 067- A waiver continuation for K 067 THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE is being requested for which DEPARTMENT'S ACCEPTANCE. YOUR justification dated 5/14/2014 on form SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE CMS 2786R is attached. USED AS VERIFICATION OF COMPLIANCE. POCOK K67 W/AW for K67 UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, the 1963 and 1977 sections of Community Memorial Home were found to be not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY MAY 2 0 2014 DEFICIENCIES (K-TAG\$) TO: HEALTH CARE FIRE INSPECTIONS IN DEPT. OF PUBLIC SAFET STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

Facility ID: 00109

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		245465	B. WING			04/1	6/2014
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME				4	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DSAKIS, MN 56360		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUST FOLLOWING INFOR  1. A description of wh to correct the deficier  2. The actual, or propage of the second of the correct the deficier  3. The name and/or the responsible for correct the deficient of the second o	RECTION FOR EACH INCLUDE ALL OF THE MATION:  nat has been, or will be, done ncy.  cosed, completion date.  itle of the person ction and monitoring to ce of the deficiency.  eyed as two separate y Memorial Home is a 2 story ement. The building was erent times. The original cted in 1963, is one story and e of Type II(000) y, a one story, Type II(000), ing room was added. 1963 building and the 1977 instruction type allowed for ese buildings were surveyed ing. The 2 story 2008 littion was surveyed as new  ire sprinklered throughout. e alarm system that includes the corridors and spaces that is monitored for ement notification. The facility beds and had a census of 40	K	000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			SURVEY PLETED
		245465	B. WING_			04	16/2014
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME				41	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET SAKIS, MN 56360	***************************************	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE				
K 000 K 067 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD			067	See page one		
	with the provisions of in accordance with the	and air conditioning comply section 9.2 and are installed e manufacturer's 5.2.1, 9.2, NFPA 90A,					
	Based on observation revealed that the facilipart of the air distribution make-up air for the sleexhaust, throughout the accordance with NFP, practice could allow the totravel far from the f	eeping rooms' bathroom he building which is not in A 90A. This deficient ne products of combustion ire origin and negatively aff and visitors by restricting					
	12:00 PM on 04/16/14 Facility Administrator documentation and of the HVAC systems for 1977 additions have of corridors and no retur corridors. There is no resident rooms, which fans that are constant	oservations revealed that r all wings of the 1963 and fucted air supply to the					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING <b>01</b> -	(X3) C	OATE SURVEY OMPLETED	
		245465	B. WING	B. WING		
NAME OF PROVIDER OR SUPPLIER  COMMUNITY MEMORIAL HOME			410	EET ADDRESS, CITY, STATE, ZIP CODE WEST MAIN STREET AKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 067	Continued From page plenum.  This was confirmed b Environmental Service	y the Director of es (TM)	K 067			
	An annual waiver has	been previously granted.				
	:*					

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 5L8E

#### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PA	ART I - TO BE COM	PLETED BY 1	THE STAT	E SURVEY	YAGE	NCY	I	acility ID: 00109
MEDICARE/MEDICAID PI (L1) 245465  2.STATE VENDOR OR MEDI (L2) 668340100	(L3) COMMU	AND ADDRESS OF FACILITY  MMUNITY MEMORIAL HOME  WEST MAIN STREET  AKIS, MN		(L6) <b>56360</b>		4. TYPE OF ACTION:  1. Initial  3. Termination  5. Validation	2 (L8) 2. Recertification 4. CHOW 6. Complaint		
5. EFFECTIVE DATE CHAN (L9)	GE OF OWNERSHIP	7. PROVIDER/SUI	7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD		<u>02</u> 13 PTIP	(L7) 22 CLIA		7. On-Site Visit  8. Full Survey After Co	9. Other mplaint
DATE OF SURVEY     ACCREDITATION STATU     Unaccredited	<b>04/17/2014</b> (L34) S: (L10)		06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPI			FISCAL YEAR ENDING 06/30	DATE: (L35)
2 AOA	3 Other								
11LTC PERIOD OF CERTIFI	CATION	10.THE FACILITY	IS CERTIFIED AS	:					
From (a): To (b):		A. In Compliar Program Re Compliance	equirements		And/Or Approved Waivers Of The Following Requirements:  2. Technical Personnel 6. Scope of Services Limit 3. 24 Hour RN 7. Medical Director				
12. Total Facility Beds	<b>50</b> (L18		Acceptable POC		4.	. 7-Day	RN (Rural SNF) afety Code	8. Patient Room 8	
13.Total Certified Beds	<b>50</b> (L17)		pliance with Programents and/or Applied		* Code:	E	<b>3</b> *	(L12)	
14. LTC CERTIFIED BED BR	EAKDOWN				15. FACILI	TY MEE	ETS		
18 SNF	18/19 SNF 19 SN 50	NF ICF	IID		1861 (e) (	(1) or 18	61 (j) (1):	(L15)	
(L37)	(L38) (L39	9) (L42)	(L43)						
16. STATE SURVEY AGENC	Y REMARKS (IF APPLICAB	LE SHOW LTC CANCELI	LATION DATE):						
See Attached Remarks									
17. SURVEYOR SIGNATURE	3	Date :			18. STATE	SURVE	EY AGENCY APP	PROVAL	Date:
LoAnn De	Gagne, HFE NE	II 0	6/03/2014	(L19)	Kate JohnsTon, Enforcement Specialist 06/19/2014				
	PART II - 7	TO BE COMPLETE	D BY HCFA R	EGIONAL	OFFICE (	OR SI	NGLE STAT	E AGENCY	
19. DETERMINATION OF E  1. Facility is E  2. Facility is n	igible to Participate	RIGH	IPLIANCE WITH O	CIVIL	21.	2. Ov		al Solvency (HCFA-2572)  nterest Disclosure Stmt (HCFA	L-1513)
22. ORIGINAL DATE	23. LTC AGRE	EEMENT 2	24. LTC AGREEM	ENT	26. TERM	/INATIO	ON ACTION:	(	L30)
OF PARTICIPATION <b>04/01/1987</b>	BEGINNI	ING DATE	ENDING DAT	E	VOLUNTA 01-Merger,		00	<u> </u>	CARY eet Health/Safety
(L24)	(L41)		(L25)				V/ Reimbursemen	nt 06-Fail to M	eet Agreement
25. LTC EXTENSION DATE		TIVE SANCTIONS sion of Admissions:					ry Termination Withdrawal	<u>OTHER</u> 07-Provider 00-Active	Status Change
	(L27) B. Rescind	1 Suspension Date:	(L44) (L45)					00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/C			30. REMA	RKS			
	(L28)	03001		(L31)			' Emailed	CMS 06/20/20	14 Co.
31. RO RECEIPT OF CMS-15	39	32. DETERMINATION	OF APPROVAL DA	ATE .					
	(L32)			(L33)	DETERN	MINAT	TON APPROV	VAL	

### CENTERS FOR MEDICARE & MEDICAID SERVICES

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00109

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

Page 2

Provider Number: 24-5465

Item 16 Continuation for CMS-1539

At the time of the extended survey completed 04/17/14, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required as evidenced by the attached CMS-2567. The facility's request for a continuing waiver involving the deficiency cited at K67 has been recommended. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

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

PRINTED: 05/06/2014 FORM APPROVED

OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 245465 04/16/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 410 WEST MAIN STREET COMMUNITY MEMORIAL HOME **OSAKIS, MN 56360** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION (FACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) **INITIAL COMMENTS** K 000 K 000 FIRE SAFETY K 067- A waiver continuation for K 067 THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE is being requested for which DEPARTMENT'S ACCEPTANCE. YOUR justification dated 5/14/2014 on form SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE CMS 2786R is attached. USED AS VERIFICATION OF COMPLIANCE. POCOK K67 W/AW for K67 UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, the 1963 and 1977 sections of Community Memorial Home were found to be not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY MAY 2 0 2014 DEFICIENCIES (K-TAG\$) TO: HEALTH CARE FIRE INSPECTIONS IN DEPT. OF PUBLIC SAFET STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

Facility ID: 00109

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/06/2014 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES		OMB NO	O. 0938-0391		
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION 11 - Main Building 01	(X3) DATE S COMPL	
		245465	B. WING_			04/1	6/2014
	ROVIDER OR SUPPLIER  TY MEMORIAL HOME			4	STREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET DSAKIS, MN 56360		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IE ATE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUST FOLLOWING INFOR  1. A description of wh to correct the deficier  2. The actual, or propagation of the seponsible for correct prevent a reoccurrent of the secondary of the second	RECTION FOR EACH INCLUDE ALL OF THE MATION:  nat has been, or will be, done ncy.  cosed, completion date.  itle of the person ction and monitoring to ce of the deficiency.  eyed as two separate y Memorial Home is a 2 story ment. The building was rent times. The original cted in 1963, is one story and e of Type II(000) y, a one story, Type II(000), ng room was added.  1963 building and the 1977 nstruction type allowed for ese buildings were surveyed ing. The 2 story 2008 lition was surveyed as new  ire sprinklered throughout. I alarm system that includes the corridors and spaces I that is monitored for ment notification. The facility beds and had a census of 40	K	000			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 05/06/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION I - MAIN BUILDING 01	(X3) DATE SURVE	
		245465	B. WING_			04	16/2014
	ROVIDER OR SUPPLIER			41	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST MAIN STREET SAKIS, MN 56360	***************************************	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 000 K 067 SS=F	NOT MET as evidend NFPA 101 LIFE SAFE	2 CFR, Subpart 483.70(a) is eed by: ETY CODE STANDARD	K	067	See page one		
	with the provisions of in accordance with the	and air conditioning comply section 9.2 and are installed e manufacturer's 5.2.1, 9.2, NFPA 90A,					
	Based on observation revealed that the facilipart of the air distribution make-up air for the sleexhaust, throughout the accordance with NFP, practice could allow the totravel far from the f	eeping rooms' bathroom he building which is not in A 90A. This deficient ne products of combustion ire origin and negatively aff and visitors by restricting					
	12:00 PM on 04/16/14 Facility Administrator documentation and of the HVAC systems for 1977 additions have of corridors and no retur corridors. There is no resident rooms, which fans that are constant	oservations revealed that r all wings of the 1963 and fucted air supply to the					

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/06/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE C A. BUILDING <b>01</b> -	(X3)	(X3) DATE SURVEY COMPLETED		
		245465	B. WING			04/16/2014	
	ROVIDER OR SUPPLIER	•	410	EET ADDRESS, CITY, STATE, ZIP CODI WEST MAIN STREET AKIS, MN 56360	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 067	Continued From page plenum.  This was confirmed b Environmental Service	y the Director of es (TM)	K 067				
	An annual waiver has	been previously granted.					
	:*						

### Sheehan, Pat (DPS)

From:

Sheehan, Pat (DPS)

Sent:

Friday, May 23, 2014 12:09 PM

To:

'rochi\_lsc@cms.hhs.gov'

Cc:

james.a.anderson@state.mn.us; 'Dave Carlson'; Dietrich, Shellae (MDH); 'Fiske-Downing,

Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen

(MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)

Subject:

Community Memorial Home (245466) 2014 K67 Annual Waiver Request - Previously

Approved - No Changes

This is to inform you that Community Memorial Home is again requesting an annual waiver for K67, corridors as a plenum. The exit date was 4-17-14.

I am recommending that CM approve this waiver request.

# Patrick Sheehan. Fire Safety Supervisor

Office: 651-201-7205 Cell: 651-470-4416 **Health Care & Corrections Fire Inspections** 

Minnesota State Fire Marshal Division 445 Minnesota St., Suite 145, St Paul, MN 55101-5145

FAX: 651-215-0525 Web: fire.state.mn.us

Community Memorial Home (CMH) at Osakis, MN Inc

# PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

as a plenum. the corridors are used 1999 Edition because 9.2 and NFPA 90A, with LSC (00) Section CMH does not comply and Air Conditioning **K**067 (HVAC) equipment at Heating, Ventilation PROVISION NUMBER(S) W A continuing waiver is being requested for K067 for the following reasons ⋗ An extreme financial hardship on Community Memorial Home(CMH) will result from compliance because: If this waiver is approved, the safety of building occupants will not be compromised because: 1. Revised estimates (5-14-14, attached) show that compliance with NFPA 90A will cost between CMH was built under Type II construction standards; CMH is completely protected by a supervised sprinkler system installed in accordance with NFPA 13; Walls, floors, ceilings and vertical openings at CMH already resist the passage of smoke Non-complying systems are allowed to be used under LSC(00), 9.2.1. HVAC ventilation fans automatically shut down upon activation of a fire alarm or upon detection of Asbestos abatement during installation would cost between \$59,483 and \$81,900; and The electrical system at CMH would need to be modified at a cost that may exceed \$42,000; \$446,120 and \$579,299. These dollars are not available under current reimbursement rules; JUSTIFICATION

Resident sleeping rooms are all equipped with single station battery operated smoke detectors

The property of CMH is smoke and tobacco free with signs posted to that effect:

All CMH Corridors are equipped with a compliant UL listed smoke detection system;

The local fire department is located 6 blocks away and can respond to an alarm in less than 10 mins.;

CMH has an approved fire safety plan and is compliant with all other fire safety requirements; and

A continuing warver has been approved annually in the past for Community Memorial. month 5-14-2014

Requested by: David E. Carlson, Administrator 5-14-2014

Surveyor (Signature)	Title		Office	Date
Fire Authority Official (Signature)	Title	Fire Safety Supervisor	Office <b>State Fire</b> Marshal	Date \$-25-14



PRELIMINARY MASTER BUDGET
Galeon - Community Memorial Home
PREPARED: 5/14/2014

3315 Roosevelt Road, Ste. 100 St. Cloud MN 56301

Bus. (320) 251-0262 Fax: (320) 251-5749

Low Range 24,000 S.F. High Range 24,000 S.F.

**DOLLARS** 

**DOLLARS** 

I. LAND	SUBTOTAL LAND	\$ p		\$		
II. CONSTRUCTION COSTS						
GENERAL CONDITIONS		\$ 26,523	\$ 1.11	\$	32,448	\$ 1.35
INTERIOR FINISHES / DEMO	)	\$ 19,096	\$ 0.80	\$	29,203	\$ 1.22
MECHANICAL		\$ 203,693	\$ 8.49	\$	259,584	\$ 10.82
FIRE SPRINKLER	W.	\$ 5,305	\$ 0.22	\$	10,816	\$ 0.45
ELECTRICAL		\$ 37,132	\$ 1.55	\$	43,264	\$ 1.80
CONTINGENCY	8	\$ 30,000	\$ 1.25	\$	38,000	\$ 1.58
SUBTOTAL CONS	STRUCTION COSTS	\$ 321,748	\$ 13.41	\$	413,315	\$ 17.22
III. SOFT COSTS						
FEES / PERMITS / PRINTING	3	\$ 64,890	\$ 2.70	\$	84,084	\$ 3.50
OTHER		\$ 	\$ 	\$	-	\$ 
SUBTO	OTAL SOFT COSTS	\$ 64,890	\$ 2.70	\$	84,084	\$ 3.50
IV. OWNER ITEMS						
FURNITURE/FIXTURES/EQU	JIPMENT	\$		\$		
OTHER - ASBESTOS ABATE	MENT	\$ 59,483	\$ 2.48	_\$_	81,900	\$ 3.41
SUBTOTAL OW	NER ITEMS COSTS	\$ 59,483	\$ 2.48	\$	81,900	\$ 3.41
V. TOTAL PROJECT COST		\$ 446,120	\$ 18.59	\$	579,299	\$ 24.14

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

F5465023

PRINTED: 05/06/2014 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 02 - 2 BLDG PT/OT WELLNESS CENTER 245465 B. WING 04/16/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 410 WEST MAIN STREET . COMMUNITY MEMORIAL HOME **OSAKIS, MN 56360** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY)

K 000 INITIAL COMMENTS

K 000

FIRE SAFETY

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, the 2008 Wellness Center Addition of Community Memorial Home was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC),

Chapter 18 New Health Care.

Community Memorial Home was surveyed as two separate buildings. The 2008 Wellness Center addition is a 2-story building with no basement, and was determined to be of Type II (111) construction.

The building is fully fire sprinklered throughout and has a fire alarm system that includes smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.

The requirement at 42 CFR, Subpart 483.70(a) is MET.

\$ 5-29-14



LABORATORY DIRECTOR'S OR PROVIDENSUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

Event ID: 5L8E21

Facility ID: 00109

If continuation sheet Page 1 of 1

FIRE SAFETY SURVEY REPORT	Γ 2000 CODE - HEALTH CA	ARE	1. (A) PROVIDER NUM	MBER 1. (B) ME	DICAID I.D. NO.
Medicare -	Medicaid	н	<sub>&lt;1</sub> 245465	K2	
	PART I — Life Safety	•		,,,	9.
	PART IV — Waiver F	Recommend	dation Form		
Identifying information as shown in applicable	records. Enter changes, if any, ale	ongside ead	ch item, giving dat	e of change.	
2. NAME OF FACILITY 2. (A) 1	MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRE	SS OF FACILITY (STE	REET, CITY, STATE, Z	(IP CODE) A Fully Sprinklered
Community Memorial Home	A. BUILDING Bldg. 01	440 W/a	at Main Otas at		(All required areas are sprinklered)
Committee and the me	B. WING		st Main Street		B. Partially Sprinklered
	C. FLOOR	Osakis,	MN 56360		(Not all required areas are sprinklere
кз					C. None (No sprinkler system)
3. SURVEY FOR 4. DAT	E OF SURVEY	DATE OF PLA	AN APPROVAL	SURVEY UNDER	T NO 180
✓ MEDICARE ✓ MEDICAID K4	1/16/2014	K6		5. 000 EXISTING	6. 2000 NEW
5. SURVEY FOR CERTIFICATION OF					
1 HOSPITAL 2. SKILLED/NURSING	FACILITY 4. OCF/MR UN	DER HEALTH	CARE 5	HOSPICE	
IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIA	TE ITEM(S) BELOW		3. F DISTI	NCT PART OF HOSPITA	AL, IS HOSPITAL ACCREDITED?
1. ENTIRE FACILITY 2. DISTINCT PART OF	(SPECIFY)			ES bono	
6. BED COMPOSITION					
a. TOTAL NO. OF BEDS b. NUMBER OF HOSPI CERTIFIED FOR MEI		BEDS 50	d. NUMBER OF SK CERTIFIED FOR	KILLED BEDS MEDICAID50_	e. NUMBER OF NF or ICF/MR BEDS 0 CERTIFIED FOR MEDICAID
7. A THE FACILITY MEETS, BASED UPON (CHECK	( ALL APPROPRIATE BOXES)				
0 -			$\sim$		
1. OCOMPLIANCE WITH ALL PROVISIONS	2 ACCEPTANCE OF A PLAN OF COR	RRECTION 3	. OECOMMENDED	WAIVERS 4	ES 5 PERFORMANCE BASED DESIGN
B. THE FACILITY DOES NOT MEET THE STAND	ARD			_	
SURVEYOR (Signature)	TITLE	OFFIC	CE		DATE
James Hodroon	Deputy State	Sto	to Eiro Marabal		
SURVEYOR ID 27200	Fire Marshal	Sia	te Fire Marshal		04/16/2014
FIRE AUTHORITY OFFICIAL (Signature)	TITLE	OFFIC	CE		DATE
T.	Fire Safety Supervisor	Sta	te Fire Marshal		4-21-14

ID PREFIX				MET	NOT MET	N/A	REMARKS
	ı	PART I - LSC REQUIREMENTS -	Items in italics relate to the FSES				
		BUILDING CO	NSTRUCTION				
K11	the res ad sh lea	the building has a common wa e common wall is a fire barrier sistance rating constructed of raddition. Communicating opening hall be protected by approved s ast 1½ hour fire resistance rations. 3.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 1	materials as required for the gs occur only in corridors and self-closing fire doors with at ang				
K12	Bu	000 EXISTING uilding construction type and he 0.1.6.2, 19.1.6.3, 19.1.6.4, 19.3	eight meets one of the following:				
	1	I (443), I (332), II (222)	Any Height				
	2	II (111)	One story only (non-sprinklered).				
	3	II (111)	Not over three stories with complete automatic sprinkler system.				
	4	III (211)					
	5	V (111)	Not over two stories with complete automatic				
	6	IV (2HH)	sprinkler system.				
	7	II (000)					
	8	III (200)	Not over one story with complete automatic				
	9	V (000)	sprinkler system.				
	Giv nui are	Building contains fire treated wave a brief description, in REMAR amber of stories, including basence located, location of smoke or approval. Complete sketch or attailding as appropriate.	KS, of the construction, the ments, floors on which patients fire barriers and dates of				

					NOT		
ID PREFIX				MET	NOT MET	N/A	REMARKS
K12		00 NEW					
		lding construction type and height 1.6.2, 18.1.6.3, 18.3.5.1.	t meets one of the following:				
	10.	1.0.2, 10.1.0.3, 10.3.3.1.					
	1	I (443), I (332), II (222)	Any height with complete automatic sprinkler system				
	2	II (111)	Not over three stories with complete automatic sprinkler system	_			
	3	III (211)					
	4	V (111)	Not over one story with complete automatic				
	5	IV (2HH)	sprinkler system.				
	6	II (000)					
	7	III (200)	Not Permitted				
	8	V (000)	TVOCT CHINICOL				
	□ Building contains fire treated wood.  Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.						
K103	con	erior walls and partitions in building estruction shall be noncombustible terials. 18.1.6.3, 19.1.6.3	gs of Type I or Type II or limited-combustible				
	trea	dicate N/A for existing buildings us ated wood studs within non-load buttions.)	sing listed fire retardant earing one-hour rated				

ID		MET	NOT	N/A	REMARKS
PREFIX	INTERIOR FINIOU	IVILI	MET	IN/A	TILMATIKO
	INTERIOR FINISH				
K14	2000 EXISTING Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than ½8 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 Indicate flame spread rating/s				
	2000 NEW  Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower half of corridor walls, not exceeding 4ft in height, may have a Class C flame spread rating. 10.2, 18.3.3.1, 18.3.3.2, NFPA TIA 00-2  Indicate flame spread rating/s				
K15	2000 EXISTING  Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2  Indicate flame spread rating/s				
	2000 NEW  Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (Rooms not over 4 persons in capacity may have a flame spread rating of Class A, Class B, or Class C). 18.3.3.1, 18.3.3.2.  Indicate flame spread rating/s				

ID PREFIX		MET	NOT MET	N/A	REMARKS
(16	2000 EXISTING  Newly installed interior floor finish complying with 10.2.7 shall be permitted in corridors and exits if Class I. 19.3.3.3  In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, no interior floor finish requirements shall apply.				
	CORRIDOR WALLS AND DOORS				
<b>K17</b>	Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.)  19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5  If the walls have a fire resistance rating, give rating if the walls terminate at the underside of a ceiling, give a brief description in REMARKS, of the ceiling, describing the ceiling throughout the floor area.				
	2000 NEW  Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.4, 18.3.6.5				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K18	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3		IVIL I		
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
	2000 NEW  Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3				
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
K19	Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) In other than smoke compartments containing patient bedrooms, miscellaneous opening are permitted in vision panels or doors provided the aggregate area of the opening per room does not exceed 20 in.² and the opening is installed in bottom half of the wall (80 in.² in fully sprinklered buildings).  18.3.6.5, 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5				
	40.0700P.(00/0040)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	VERTICAL OPENINGS				
K20	2000 EXISTING				
	Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	2000 NEW				
	Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.2.5.6, 8.2.5, 18.3.1.1.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K21	Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:				
	<ul> <li>□ (a) The required manual fire alarm system and</li> <li>□ (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and</li> </ul>				
	☐ (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2				
	Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1				
	Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.				

			NGT	_
ID PREFIX		MET	NOT MET	N/A
	Describe method used in REMARKS			
	SMOKE COMPARTMENTATION AND CONTROL			
K23	2000 EXISTING			
	Smoke barriers shall be provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2			
	2000 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Smoke barriers shall also be provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2			
K24	The smoke compartments shall not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier shall not exceed 200 feet. 18.3.7.1, 19.3.7.1			
	Detail in REMARKS zone dimensions including length of zones and dead end corridors.			
K25	2000 EXISTING			
	Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5			
	2000 NEW			
	Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5			
K26	Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.4, 19.3.7.4			
	MO 0700D (00/0040)			

ID PREFIX				MET	NOT MET	N/A	REMARKS
K27	2000 EXISTING  Doors in smoke barriers rating or are at least 1¾ Non-rated protective plathe bottom of the door a comply with 7.2.1.14. Do closing in accordance wirequired to swing with exprequired. 19.3.7.5, 19.3.	inch thick solid to tes that do not exercised. However, pors shall be self th 19.2.2.2.6. Swaress and positive	oonded core wood. xceed 48 inches from rizontal sliding doors -closing or automatic- vinging doors are not				
	2000 NEW  Doors in smoke barriers have rating or are at least 1¾ in rated protective plates that of the door are permitted. 7.2.1.14. Swinging doors in an opposite direction. Devels or astragals are relatching is not required.	nch thick solid bor at do not exceed 4 Horizontal sliding shall be arranged Doors shall be self quired at the mee	nded core wood. Non- 8 inches from the bottom doors comply with so that each door swings -closing and rabbets, ting edges. Positive				
K28	2000 EXISTING  Door openings in smoke width of 32 inches (81 cr 19.3.7.7						_
	2000 NEW  Door openings in smoke horizontal doors shall pro						
	Provider Type	Swinging Doors	Horizontal Sliding Doors				
	Hospitals and Nursing Facilities	41.5 inches (105 cm)	83 inches (211 cm)				
	Psychiatric Hospitals and Limited Care Facilities	32 inches (81 cm)	64 inches (163 cm)				
	18.3.7.7						

Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area							
Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5.  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area	D EFIX			MET		N/A	REMARKS
accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area		ducts are protec	eted in				
penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area							
where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area  Automatic Sprinkler Separation N/A  A. Boller and Fuel-Fired Heater Rooms  c. Laundries (greater than 100 sg feet)  d. Repair Shops  e. Laboratories (if classified a Severe Hazard - see K31)  1. Combustible Storage Rooms Spaces (over 50 sq feet)  g. Trash Collection Rooms  i. Solled Linen Rooms  i. Solled Linen Rooms							
provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area  a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater han 100 sq feet) d. Repair Shops and Paint Shops l. Laboratoriae (if classified a Swere Hazard - see K31) I. Combustiles (Greater han 100 sq feet) J. Trash Collection Rooms L. Solled Linen Rooms							
Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area  Automatic Sprinkler  Automatic Sprinkler  Separation  N/A  A. Boller and Fuel-Fired Heater Rooms  c. Laundries (greater than 100 sq feet)  d. Repair Shoppa and Paint Shoppa  e. Laboratories (if classified a Severe Hazard - see K31)  1. Combustible Storage Rooms/Spaces (over 50 ag feet)  g. Trash Collection Rooms  i. Solied Linen Rooms							
to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area  a. Boller and Fuel-Fired Heater Rooms c. Laundries (greater finan 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms(Spaces (over 50 sq feet) g. Trash Collection Rooms l. Solled Linen Rooms l. Solled Linen Rooms	provided for adjacent smoke compa	artments. 18.3.7	7.3, 19.3.7.3.				
to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area  a. Boller and Fuel-Fired Heater Rooms c. Laundries (greater finan 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms(Spaces (over 50 sq feet) g. Trash Collection Rooms l. Solled Linen Rooms l. Solled Linen Rooms	Hospitals may apply a 6-year damp	er testing inter	val conforming				
maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms(Spaces (over 50 sq feet) g. Trash Collection Rooms l. Solied Linen Rooms							
Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area							
HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area							
One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area	Describe any mechanical smoke co	ntrol system in	REMARKS.				
One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area	HAZARD	OUS AREAS					
an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area	2000 EXISTING						
an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area	One hour fire rated construction (wi	th ¾ hour fire-r	ated doors) or				
with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area	· ·		,				
approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area							
areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area  Automatic Sprinkler  Beparation  Automatic Sprinkler  Beparation  N/A  Bepair Shops and Paint Shops  Beparation  C. Laundries (greater than 100 sq feet)  Department of the door are permitted. 19.3.2.1							
partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area  a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms							
field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area	areas shall be separated from othe	r spaces by sm	oke resisting				
field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area	partitions and doors. Doors shall be	self-closing ar	nd non-rated or				
the bottom of the door are permitted. 19.3.2.1  Area Automatic Sprinkler Separation N/A  a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms							
Area Automatic Sprinkler Separation N/A  a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms			o mones nom				
a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms	the bottom of the door are permitte	u. 13.5.2.1					
a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms	Aroa	Automatic Sprinkler	Sonaration N/A				
c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms		Automatic Sprinkler	Separation IN/A				
d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms							
e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms							
g. Trash Collection Rooms i. Soiled Linen Rooms							
i. Soiled Linen Rooms	f. Combustible Storage Rooms/Spaces (over 50 sq feet)						
	i. Soiled Linen Rooms						
	are deficient in REMARKS.						
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.	MAC 0700D (00/0040)			1	1		

ID			NOT		D=11121/2
PREFIX		MET	MET	N/A	REMARKS
	2000 NEW				
	Hazardous areas are protected in accordance with 8.4. The				
	areas shall be enclosed with a one hour fire-rated barrier, with a				
	·	·			
	3/4 hour fire-rated door, without windows (in accordance with				
	8.4). Doors shall be self-closing or automatic closing in				
	accordance with 7.2.1.8. Hazardous areas are protected by a				
	sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1.				
	Area Automatic Sprinkler Separation N/A	1			
	a. Boiler and Fuel-Fired Heater Rooms				
	c. Laundries (greater than 100 sq feet)				
	d. Repair, Maintenance and Paint Shops				
	e. Laboratories (if classified a Severe Hazard - see K31)				
	f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq feet)				
	g. Trash Collection Rooms				
	i. Soiled Linen Rooms	1			
	m. Combustible Storage Rooms/Spaces (over 100 sq feet)				
		'			
	Describe the floor and zone locations of hazardous areas that				
	are deficient in REMARKS.				
			-		-
K30	Gift shops shall be protected as hazardous areas when used for	•			
	storage or display of combustibles in quantities considered				
	hazardous. Non-rated walls may separate gift shops that are no	t			
	considered hazardous, have separate protected storage and that				
	are completely sprinkled. Gift shops may be open to the corrido				
	if they are not considered hazardous, have separate protected				
	storage, are completely sprinklered and do not exceed 500				
	square feet. 18.3.2.5, 19.3.2.5				
	Area Automatic Sprinkler Separation N/A  L. Gift Shop storing hazardous quantities				
	of combustibles				

			NOT		
ID PREFIX		MET	NOT MET	N/A	REMARKS
K211	Where Alcohol Based Hand Rub (ABHR) dispensers are installed:  The corridor is at least 6 feet wide  The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)  The dispensers shall have a minimum spacing of 4 ft from each other  Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.  Dispensers are not installed over or adjacent to an ignition source.  If the floor is carpeted, the building is fully sprinklered.  18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623				
	EXITS AND EGRESS				
K22	Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1				
K32	Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2				
K33	2000 EXISTING Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1				
	If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box. □				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	l				4

ID   MET   NOT   N/A	
PREFIX MET N/A	
2000 NEW	
Exit enclosures (such as stairways) in buildings four stories or	
more are enclosed with construction having a fire resistance rating of at least two hours, are arranged to provide a continuous	
path of escape, and provide a protection against fire and smoke	
from other parts of the building. In all buildings less than four	
stories, the enclosure is at least one hour. 7.1.3.2, 8.2.5.2,	
8.2.5.4, 18.3.1.1, 18.2.2.3	
If enclosures are less than required, give a brief description and specific location in REMARKS.	
K34 Stairways and smokeproof enclosures used as exits are in	
accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4	
K35 The capacity of required mean of egress is based on its width, in accordance with 7.3.	
K36 Travel distance (exit access) to exits are measured in	
accordance with 7.6.	
• Room door to exit ≤ 100 ft (≤ 150 ft sprinklered)	
<ul> <li>Point in room or suite to exit ≤ 150 ft (≤ 200 ft sprinklered)</li> </ul>	
• Point in room to room door ≤ 50 ft	
• Point in suite to suite door ≤ 100 ft 18.2.6, 19.2.6	
K37 2000 EXISTING	
Existing dead-end corridors shall be permitted to be continued to be used if it is impractical and unfeasible to alter them so that	
exists are accessible in not less than two different directions	
from all points in aisles, passageways, and corridors. 19.2.5.10	
2000 NEW	
Every exit and exit access shall be arranged so that no corridor,	
aisle or passageway has a pocket or dead-end exceeding 30 feet, 18.2.5.10	
K38 Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1	
K39 2000 EXISTING	
Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3	
Extractess shall be at least 4 leet. 19.2.3.3	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW				
	Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet. 18.2.3.3, 18.2.3.4				
K40	2000 EXISTING				
	Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. An exception is provided for existing 34-inch doors in existing occupancies. 19.2.3.5				
	2000 NEW				
	Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 41.5 inches in clear width Doors in exit stairway enclosures shall be no less than 32 inches in clear width. In psychiatric hospitals or limited care facilities (e.g.,ICF/MD providing medical treatment) doors are at least 32 inches wide. 18.2.3.5				
K41	All sleeping rooms have a door leading to a corridor providing access to an exit or have a door leading directly to grade. One room may intervene in accordance with 18.2.5.1, 19.2.5.1  If doors lead directly to grade from each room, check this box.				
K42	Any patient sleeping room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 18.2.5.2, 19.2.5.2				
K43	Patient room doors are arranged such that the patients can open the door from inside without using a key.				
	Special door locking arrangements are permitted in facilities. 18.2.2.2.4, 18.2.2.2.5, 19.2.2.2.4, 19.2.2.2.5				
	If door locking arrangement without delay egress is used indicate in REMARKS 18.2.2.2.2, 19.2.2.2.2				
K44	Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5, 19.2.2.5				
K47	Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1				
	(Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)				

		Т		
ID PREFIX		MET	NOT MET	N/A
K72	Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1			
	ILLUMINATION			
K45	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8			
K46	Emergency lighting of at least 1½ hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.			
K105	2000 NEW (INDICATE N/A FOR EXISTING)			
	Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the Life Safety Branch of the electrical system described in NFPA 99. 18.2.9.2., 18.2.10.2 (Indicate N/A if life support equipment is for emergency purposes only).			
	EMERGENCY PLAN AND FIRE DRILLS	1	1	I
K48	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1			
K50	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2			

———ID			NOT		
PREFIX		MET	NOT MET	N/A	REMARKS
	FIRE ALARM SYSTEMS				
K51	A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6				
K52	A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,				
K155	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8				
K53	2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES) In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70				
	40 0700D (00 (0040)				Doge 16

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW (NURSING HOME AND EXISTING LIMITED CARE FACILITIES) An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridor.) Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.3				
K109	2000 EXISTING LIMITED CARE FACILITIES (INDICATE N/A FOR HOSPITALS OR NURSING HOMES)  An automatic smoke detection system is installed in all corridors with detector spacing no further apart than 30 ft on center in accordance with NFPA 72. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridors.) Such detectors are electrically interconnected to the fire alarm system. 19.3.4.5.1  Smoke Detection System  □ Corridors □ Rooms				
K54	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3  Give a brief description, in REMARKS of any smoke detection system which may be installed.				
K55	2000 EXISTING  Every patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8  2000 NEW  Every patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms				

ID		MET	NOT	N/A	REMARKS
PREFIX	intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8		MET		
(60	Initiation of the required fire alarm systems shall be by manual fire alarm initiation, automatic detection, or extinguishing system operation. 18.3.4.2, 19.3.4.2, 9.6.2.1				
	AUTOMATIC SPRINKLER SYSTEMS				
56	2000 EXISTING				
	Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13				
	2000 NEW				
	There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1.				
154	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1.				
	A. Date sprinkler system last checked and necessary maintenance provided				

		_		
ID PREFIX		MET	NOT MET	N/A
	B. Show who provided the service			
	C. Note the source of water supply for the automatic sprinkler system.			
	(Provide, in REMARKS, information on coverage for any non-required or partial automatic sprinkler system.)			
K61	Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72			
K62	Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5			
K63	Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13			
K64	Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6			
	SMOKING REGULATIONS			
K66	Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4, 8-6.4.2 (NFPA 99)			
	(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the internationa symbol for no smoking.			
	Exception: In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in use areas are not required. (Note: This exception is not applicable to medical gas storage areas.) 8-3.1.11.3 (NFPA 99)			

			1		
ID PREFIX		MET	NOT MET	N/A	REMARKS
	(2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision.				
	(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.				
	(4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.				
	BUILDING SERVICE EQUIPMENT				
K67	Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2				
K68	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2, 19.5.2.2.				
K69	Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96				
K70	Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 18.7.8, 19.7.8				
K71	Rubbish Chutes, Incinerators and Laundry Chutes. 18.5.4, 19.5.4, 9.5, 8.4, NFPA 82				
	(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with 9.5.				
	(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7.				
	(3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4.				

———ID			NOT		
PREFIX		MET	NOT MET	N/A	REMARKS
	(4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use.				
K160	2000 EXISTING				
	Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record.				
	Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators & Escalators. All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. 9.4.2, 9.4.3, 19.5.3				
	(Includes firefighters service <b>phase I</b> key recall and smoke detector automatic recall, firefighters service <b>phase II</b> emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
	2000 NEW				
	Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record.				
	New elevators conform to ASME/ANSI A17.1, Safety Code for Elevators and Escalators, including Fire Fighter's Service Requirements. 9.4.2, 9.4.3, 18.5.3				
	(Includes firefighters service <b>phase I</b> key recall and smoke detector automatic recall, firefighters service <b>phase II</b> emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
K161	2000 EXISTING				
	Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.				
	All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.2.2				
					, t

		1			T
ID PREFIX		MET	NOT MET	N/A	REMARKS
	(Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.)				
	2000 NEW	1			
	Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.				
	All escalators and conveyors comply with ASME/ANSI A17.1, Safety Code for Elevators and Escalators. 18.5.3, 9.4.2.1				
	FURNISHINGS AND DECORATIONS				
<b>K73</b>	Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4				
<b>&lt;</b> 74	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13				
	☐ Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2.				
	□ Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3				
	☐ Newly introduced upholstered furniture and mattresses means purchased since March, 2003.	3			
<b>K</b> 75	Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed .5 gal/ft² (20.4 L/m²). A	,			
01	40 0700D (00/0040)		1		

ID PREFIX		MET	NOT MET	N/A	REM
THETTA	capacity of 32 gal (121 L) shall not be exceeded within any 64-ft² (5.9-m²) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. 18.7.5.5, 19.7.5.5		IVIL I		
	LABORATORIES				
K31	Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard shall be protected in accordance with NFPA 99. (Laboratories that are not considered to be severe hazard shall meet the provision of K29.) 18.3.2.2, 19.3.2.2, Chapter 10 (NFPA 99)				
K136	Procedures for laboratory emergencies shall be developed. Such procedures shall include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with 10-2.1.3.1 (NFPA 99), 18.3.2.2., 19.3.2.1				
K131	Emergency procedures shall be established for controlling chemical spills in accordance with 10-2.1.3.2 (NFPA 99)				
K132	Continuing safety education and supervision shall be provided, incidents shall be reviewed monthly, and procedures reviewed annually shall be in accordance with 10-2.1.4.2 (NFPA 99).				
K133	Fume hoods shall be in accordance with 5-4.3, 5-6.2 (NFPA 99).				
K134	Where the eyes or body of any person can be exposed to injurious corrosive materials, suitable fixed facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. Fixed eye baths designed and installed to avoid injurious water pressure shall be in accordance with 10-6 (NFPA 99).				
K135	Flammable and combustible liquids shall be used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals.				

ID		MET	NOT	N/A	REMARKS
PREFIX		IVIEI	MET	IN/A	NEWANNS
	Storage cabinets for flammable and combustible liquids shall be constructed in accordance with NFPA 30, Flammable and Combustible liquids Code, 4-3 (NFPA 99), 10-7.2.1 (NFPA 99)				
	MEDICAL GASES AND ANESTHETIZING AREAS				
K76	<ul> <li>Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</li> <li>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</li> <li>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside.</li> <li>4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4</li> </ul>				
K77	Piped in medical gas, vacuum and waste anesthetic gas disposal systems comply with NFPA 99, Chapter 4.				
K78	<ul> <li>Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</li> <li>(a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others.</li> <li>(b) Relative humidity is maintained equal to or great than 35% 4-3.1.2.3(n) and 5-4.1.1 (NFPA 99), 18.3.2.3, 19.3.2.3</li> </ul>				
K140	<ul> <li>Medical gas warning systems shall be in accordance with NFPA 99, Standard for Health Care Facilities.</li> <li>(a) Master alarm panels are in two separate locations and have audible and visible signals.</li> <li>(b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4-3.1.2.2</li> <li>(c) Where a level 2 gas system is used, one alarm panel that complies with 4-3.1.2.2(b)3a,b,c,d and with 4-3.1.2.2(c)2,5 shall be permitted. 4-4.1 (NFPA 99) exception No. 4.</li> <li>4-3.1.2.2 (NFPA 99)</li> </ul>				
K141	Medical gas storage areas shall have a precautionary sign, readable from a distance of 5 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum:  CAUSION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99)				

	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.	MET	NOT MET	N/A	REMARKS
	NFPA 99, Standard for Health Care Facilities, Chapter 19.				
14440					
	Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows::  (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and  (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and  (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.  8-6.2.5.2 (NFPA 99)				
	ELECTRICAL AND EMERGENCY POWER				
	Hospitals and inpatient hospices with life support equipment have an Type I Essential Electric System, and nursing homes have a Type II ESS that are powered by a generator with a transfer switch and separate power supply in accordance with NFPA 99. 12-3.3.2, 13-3.3.2.1, 16-3.3.2 (NFPA 99)				
	Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1.4, 18.3.4.1, 19.3.4.1				
K108	2000 NEW (INDICATE N/A FOR EXISTING)				
	Power for Alarms, emergency communication systems, and illumination of generator set locations are in accordance with essential electrical system of NFPA 99. 18.5.1.2				
	Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)				
	The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99)				

ID			NOT		
PREFIX		MET	NOT MET	N/A	REMARKS
K146	The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source 3-6. (NFPA 99)				
K147	Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1				
K130	Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.				

### 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				
Surveyor (Signature)		Title	ffice	Date
Fire Authority Official (Signature)		Title	ffice	Date

2000 CODE

Form Approved OMB Exempt

	PORT 2000 CODE - HEALTH C are – Medicaid	ARE 1. (A) PROVIDER NUMBER 1. (A) 245465	B) MEDICAID I.D. NO.
		Code, New and Existing	
	PART IV — Waiver	Recommendation Form	
Identifying information as shown in application	cable records. Enter changes, if any, a	longside each item, giving date of change,	
2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STA	ATE, ZIP CODE) A Fully Sprinklered
Community Memorial Home	A. BUILDING Bldg 02	410 West Main Street	(All required areas are sprinklered
,,	B. WING	Osakis, MN 56360	B. Partially Sprinklered (Not all required areas are sprinklere
	C. FLOOR	Osakis, IVIIV 30300	C. None (No sprinkler system)
	кз	E	K0180
3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL SURVEY UNDE	
✓ MEDICARE ✓ MEDICAID	04/16/2014	5. 2000 EXIS	STING 6 ✓ 2000 NEW
5. SURVEY FOR CERTIFICATION OF		1	
1 HOSPITAL 2. SKILLED/NU	RSING FACILITY 4. OCF/MR UI	NDER HEALTH CARE 5 HOSPICE	
IF "2" OR "5" ABOVE IS MARKED, CHECK APPR 1. DENTIRE FACILITY 2. DISTINCT PA			OSPITAL, IS HOSPITAL ACCREDITED?
	HOSPITAL BEDS C. NUMBER OF SKILLE CERTIFIED FOR MED	D BEDS 50 d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID 5	e. NUMBER OF NF or ICF/MR BEDS 0 CERTIFIED FOR MEDICAID
7. A THE FACILITY MEETS, BASED UPON O		PRRECTION 3. DECOMMENDED WAIVERS 4	FSES 5 PERFORMANCE BASED DESIGN
B. THE FACILITY DOES NOT MEET THE			
SURVEYOR (Signature)	TITLE	OFFICE	DATE
SURVEYOR ID 27200	Deputy State Fire Marshal	State Fire Marshal	04/16/2014
FIRE AUTHORITY OFFICIAL (Signature)	TITLE	OFFICE	DATE
AS (Signature)	Fire Safety Supervisor	State Fire Marshal	4-21-14

ID PREFIX				MET	NOT MET	N/A	REMARKS
	ı	PART I - LSC REQUIREMENTS -	Items in italics relate to the FSES				
		BUILDING CO	NSTRUCTION				
K11	the res ad sh lea	the building has a common wa e common wall is a fire barrier sistance rating constructed of raddition. Communicating opening hall be protected by approved s ast 1½ hour fire resistance rations. 3.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 1	materials as required for the gs occur only in corridors and self-closing fire doors with at ang				
K12	Bu	000 EXISTING uilding construction type and he 0.1.6.2, 19.1.6.3, 19.1.6.4, 19.3	eight meets one of the following:				
	1	I (443), I (332), II (222)	Any Height				
	2	II (111)	One story only (non-sprinklered).				
	3	II (111)	Not over three stories with complete automatic sprinkler system.				
	4	III (211)					
	5	V (111)	Not over two stories with complete automatic				
	6	IV (2HH)	sprinkler system.				
	7	II (000)					
	8	III (200)	Not over one story with complete automatic				
	9	V (000)	sprinkler system.				
	Giv nui are	Building contains fire treated wave a brief description, in REMAR amber of stories, including basence located, location of smoke or approval. Complete sketch or attailding as appropriate.	KS, of the construction, the ments, floors on which patients fire barriers and dates of				

					NOT		
ID PREFIX				MET	NOT MET	N/A	REMARKS
K12		00 NEW					
		lding construction type and height 1.6.2, 18.1.6.3, 18.3.5.1.	t meets one of the following:				
	10.	1.0.2, 10.1.0.3, 10.3.3.1.					
	1	I (443), I (332), II (222)	Any height with complete automatic sprinkler system				
	2	II (111)	Not over three stories with complete automatic sprinkler system	_			
	3	III (211)					
	4	V (111)	Not over one story with complete automatic				
	5	IV (2HH)	sprinkler system.				
	6	II (000)					
	7	III (200)	Not Permitted				
	8	V (000)	TVOCT CHINICOL				
	Give nun are app	Building contains fire treated wood e a brief description, in REMARK onber of stories, including baseme located, location of smoke or fire proval. Complete sketch or attach lding as appropriate.	(S, of the construction, the ents, floors on which patients barriers and dates of				
K103	con	erior walls and partitions in building estruction shall be noncombustible terials. 18.1.6.3, 19.1.6.3	gs of Type I or Type II or limited-combustible				
	trea	dicate N/A for existing buildings us ated wood studs within non-load buttions.)	sing listed fire retardant earing one-hour rated				

ID		MET	NOT	N/A	REMARKS
PREFIX	INTERIOR FINIOU	IVILI	MET	IN/A	TILMATIKO
	INTERIOR FINISH				
K14	2000 EXISTING Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than ½8 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 Indicate flame spread rating/s				
	2000 NEW  Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower half of corridor walls, not exceeding 4ft in height, may have a Class C flame spread rating. 10.2, 18.3.3.1, 18.3.3.2, NFPA TIA 00-2  Indicate flame spread rating/s				
K15	2000 EXISTING  Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2  Indicate flame spread rating/s				
	2000 NEW  Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (Rooms not over 4 persons in capacity may have a flame spread rating of Class A, Class B, or Class C). 18.3.3.1, 18.3.3.2.  Indicate flame spread rating/s				

ID PREFIX		MET	NOT MET	N/A	REMARKS
(16	2000 EXISTING  Newly installed interior floor finish complying with 10.2.7 shall be permitted in corridors and exits if Class I. 19.3.3.3  In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, no interior floor finish requirements shall apply.				
	CORRIDOR WALLS AND DOORS				
<b>K17</b>	Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.)  19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5  If the walls have a fire resistance rating, give rating if the walls terminate at the underside of a ceiling, give a brief description in REMARKS, of the ceiling, describing the ceiling throughout the floor area.				
	2000 NEW  Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.4, 18.3.6.5				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K18	2000 EXISTING  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3		IVIE I		
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
	2000 NEW  Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3				
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
K19	Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) In other than smoke compartments containing patient bedrooms, miscellaneous opening are permitted in vision panels or doors provided the aggregate area of the opening per room does not exceed 20 in.² and the opening is installed in bottom half of the wall (80 in.² in fully sprinklered buildings).  18.3.6.5, 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	VERTICAL OPENINGS				
K20	2000 EXISTING				
	Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	2000 NEW				
	Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.2.5.6, 8.2.5, 18.3.1.1.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K21	Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:				
	<ul> <li>□ (a) The required manual fire alarm system and</li> <li>□ (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and</li> </ul>				
	☐ (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2				
	Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1				
	Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.				

			No.	_
ID PREFIX		MET	NOT MET	N/A
	Describe method used in REMARKS			
	SMOKE COMPARTMENTATION AND CONTROL			
K23	2000 EXISTING			
	Smoke barriers shall be provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2			
	2000 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Smoke barriers shall also be provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2			
K24	The smoke compartments shall not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier shall not exceed 200 feet. 18.3.7.1, 19.3.7.1			
	Detail in REMARKS zone dimensions including length of zones and dead end corridors.			
K25	2000 EXISTING			
	Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5			
	2000 NEW		<del> </del>	
	Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5			
K26	Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.4, 19.3.7.4			
	40 0700D (00 (0040)			

ID PREFIX				MET	NOT MET	N/A	REMARKS
K27	2000 EXISTING  Doors in smoke barriers rating or are at least 1¾ Non-rated protective plathe bottom of the door a comply with 7.2.1.14. Do closing in accordance wirequired to swing with exprequired. 19.3.7.5, 19.3.	inch thick solid to tes that do not exercised. However, pors shall be self th 19.2.2.2.6. Swaress and positive	oonded core wood. xceed 48 inches from rizontal sliding doors -closing or automatic- vinging doors are not				
	2000 NEW  Doors in smoke barriers have rating or are at least 1¾ in rated protective plates that of the door are permitted. 7.2.1.14. Swinging doors in an opposite direction. Devels or astragals are relatching is not required.	nch thick solid bor at do not exceed 4 Horizontal sliding shall be arranged Doors shall be self quired at the mee	nded core wood. Non- 8 inches from the bottom doors comply with so that each door swings -closing and rabbets, ting edges. Positive				
K28	2000 EXISTING  Door openings in smoke width of 32 inches (81 cr 19.3.7.7						_
	2000 NEW  Door openings in smoke horizontal doors shall pro						
	Provider Type	Swinging Doors	Horizontal Sliding Doors				
	Hospitals and Nursing Facilities	41.5 inches (105 cm)	83 inches (211 cm)				
	Psychiatric Hospitals and Limited Care Facilities	32 inches (81 cm)	64 inches (163 cm)				
	18.3.7.7						

Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area							
Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5.  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area	D EFIX			MET		N/A	REMARKS
accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area		ducts are protec	eted in				
penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area							
where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area  Automatic Sprinkler Separation N/A  A. Boller and Fuel-Fired Heater Rooms  c. Laundries (greater than 100 sg feet)  d. Repair Shops  e. Laboratories (if classified a Severe Hazard - see K31)  1. Combustible Storage Rooms Spaces (over 50 sq feet)  g. Trash Collection Rooms  i. Solled Linen Rooms  i. Solled Linen Rooms							
provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area  a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater han 100 sq feet) d. Repair Shops and Paint Shops l. Laboratoriae (if classified a Swere Hazard - see K31) I. Combustiles (Greater han 100 sq feet) g. Trash Collection Rooms l. Solled Linen Rooms							
Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area  Automatic Sprinkler  Automatic Sprinkler  Separation  N/A  A. Boller and Fuel-Fired Heater Rooms  c. Laundries (greater than 100 sq feet)  d. Repair Shoppa and Paint Shoppa e. Laboratories (if classified a Severe Hazard - see K31)  1. Combustible Storage Rooms/Spaces (over 50 aq feet)  g. Trash Collection Rooms  i. Solied Linen Rooms							
to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area  a. Boller and Fuel-Fired Heater Rooms c. Laundries (greater finan 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms(Spaces (over 50 sq feet) g. Trash Collection Rooms l. Solled Linen Rooms l. Solled Linen Rooms	provided for adjacent smoke compa	artments. 18.3.7	7.3, 19.3.7.3.				
to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area  a. Boller and Fuel-Fired Heater Rooms c. Laundries (greater finan 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms(Spaces (over 50 sq feet) g. Trash Collection Rooms l. Solled Linen Rooms l. Solled Linen Rooms	Hospitals may apply a 6-year damp	er testing inter	val conforming				
maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area  a. Boiler and Fuel-Fired Heater Rooms  c. Laundries (greater than 100 sq feet)  d. Repair Shops and Paint Shops  e. Laboratories (if classified a Severe Hazard - see K31)  l. Combustible Storage Rooms(Spaces (over 50 sq feet)  g. Trash Collection Rooms  l. Solied Linen Rooms							
Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area							
HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area							
One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area	Describe any mechanical smoke co	ntrol system in	REMARKS.				
One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area	HAZARD	OUS AREAS					
an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area	2000 EXISTING						
an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area	One hour fire rated construction (wi	th ¾ hour fire-r	ated doors) or				
with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area	· ·		,				
approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area							
areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area  Automatic Sprinkler  Beparation  Automatic Sprinkler  Beparation  N/A  Bepair Shops and Paint Shops  Beparation  C. Laundries (greater than 100 sq feet)  Department of the door are permitted. 19.3.2.1							
partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area  a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms							
field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area	areas shall be separated from othe	r spaces by sm	oke resisting				
field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  Area	partitions and doors. Doors shall be	self-closing ar	nd non-rated or				
the bottom of the door are permitted. 19.3.2.1  Area Automatic Sprinkler Separation N/A  a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms							
Area Automatic Sprinkler Separation N/A  a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms			o mones nom				
a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms	the bottom of the door are permitte	u. 13.5.2.1					
a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms	Aroa	Automatic Sprinkler	Sonaration N/A				
c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms		Automatic Sprinkler	Separation IN/A				
d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms							
e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms							
g. Trash Collection Rooms i. Soiled Linen Rooms							
i. Soiled Linen Rooms	f. Combustible Storage Rooms/Spaces (over 50 sq feet)						
	i. Soiled Linen Rooms						
	are deficient in REMARKS.						
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.							
are deficient in REMARKS.	MAC 0700D (00/0040)			1	1		

				T		
ID PREFIX			MET	NOT MET	N/A	REMARKS
111111	0000 NEW			IVICI		
	2000 NEW					
	Hazardous areas are protected in accord	ance with 8.4. The				
	areas shall be enclosed with a one hour t	fire-rated barrier, with a				
	3/4 hour fire-rated door, without windows (	in accordance with				
	8.4). Doors shall be self-closing or autom					
	accordance with 7.2.1.8. Hazardous area					
	sprinkler system in accordance with 9.7,	18.3.2.1, 18.3.5.1.				
	Area Automa	atic Sprinkler   Separation   N/A				
	a. Boiler and Fuel-Fired Heater Rooms	and opinines deparation 1471				
	c. Laundries (greater than 100 sq feet)					
	d. Repair, Maintenance and Paint Shops					
	e. Laboratories (if classified a Severe Hazard - see K31)					
	f. Combustible Storage Rooms/Spaces					
	(over 50 and less than 100 sq feet) g. Trash Collection Rooms					
	i. Soiled Linen Rooms					
	m. Combustible Storage Rooms/Spaces (over 100 sq feet)					
	Describe the floor and zone locations of ha	zardous areas that				
	are deficient in REMARKS.					
	are denoient in riem, trice.					
K30	Gift shops shall be protected as hazardou	us areas when used for				
	storage or display of combustibles in qua					
	hazardous. Non-rated walls may separate					
	considered hazardous, have separate pro					
	are completely sprinkled. Gift shops may					
	if they are not considered hazardous, hav	e separate protected				
	storage, are completely sprinklered and c	lo not exceed 500				
	square feet. 18.3.2.5, 19.3.2.5					
	- equal o 10011 10101210, 10101210					
	Area Automa	tic Sprinkler   Separation   N/A				
	L. Gift Shop storing hazardous quantities					
	of combustibles					

			NOT		
ID PREFIX		MET	NOT MET	N/A	REMARKS
K211	Where Alcohol Based Hand Rub (ABHR) dispensers are installed:  The corridor is at least 6 feet wide  The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)  The dispensers shall have a minimum spacing of 4 ft from each other  Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.  Dispensers are not installed over or adjacent to an ignition source.  If the floor is carpeted, the building is fully sprinklered.  18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623				
	EXITS AND EGRESS				
K22	Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1				
K32	Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2				
K33	2000 EXISTING Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1				
	If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box. □				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	l .				4

———ID		MET	NOT	NI/A	DEMA
PREFIX		IVIE	MET	N/A	REMARKS
	2000 NEW				
	Exit enclosures (such as stairways) in buildings four stories or				
	more are enclosed with construction having a fire resistance rating of at least two hours, are arranged to provide a continuous				
	path of escape, and provide a protection against fire and smoke				
	from other parts of the building. In all buildings less than four				
	stories, the enclosure is at least one hour. 7.1.3.2, 8.2.5.2,				
	8.2.5.4, 18.3.1.1, 18.2.2.3				
	If enclosures are less than required, give a brief description and				
	specific location in REMARKS.				
K34	Stairways and smokeproof enclosures used as exits are in				
	accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4				
K35	The capacity of required mean of egress is based on its width, in				
	accordance with 7.3.				
K36	Travel distance (exit access) to exits are measured in				
	accordance with 7.6.				
	• Room door to exit ≤ 100 ft (≤ 150 ft sprinklered)				
	<ul> <li>Point in room or suite to exit ≤ 150 ft (≤ 200 ft sprinklered)</li> <li>Point in room to room door ≤ 50 ft</li> </ul>				
	<ul> <li>Point in room to room door ≤ 50 ft</li> <li>Point in suite to suite door ≤ 100 ft</li> </ul>				
	18.2.6, 19.2.6				
K37	2000 EXISTING				
	Existing dead-end corridors shall be permitted to be continued to				
	be used if it is impractical and unfeasible to alter them so that				
	exists are accessible in not less than two different directions				
	from all points in aisles, passageways, and corridors. 19.2.5.10				
	2000 NEW				
	Every exit and exit access shall be arranged so that no corridor,				
	aisle or passageway has a pocket or dead-end exceeding 30 feet. 18.2.5.10				
1400					
K38	Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1				
K39	2000 EXISTING				
1108					
	Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3				
	GAIL GOOGSS SHAII DE ALIEGSL 4 1661. 13.2.3.3				
	40, 0700D, (00/0040)				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW				
	Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet. 18.2.3.3, 18.2.3.4				
K40	2000 EXISTING				
	Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. An exception is provided for existing 34-inch doors in existing occupancies. 19.2.3.5				
	2000 NEW				
	Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 41.5 inches in clear width Doors in exit stairway enclosures shall be no less than 32 inches in clear width. In psychiatric hospitals or limited care facilities (e.g.,ICF/MD providing medical treatment) doors are at least 32 inches wide. 18.2.3.5				
K41	All sleeping rooms have a door leading to a corridor providing access to an exit or have a door leading directly to grade. One room may intervene in accordance with 18.2.5.1, 19.2.5.1  If doors lead directly to grade from each room, check this box.				
K42	Any patient sleeping room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 18.2.5.2, 19.2.5.2				
K43	Patient room doors are arranged such that the patients can open the door from inside without using a key.				
	Special door locking arrangements are permitted in facilities. 18.2.2.2.4, 18.2.2.2.5, 19.2.2.2.4, 19.2.2.2.5				
	If door locking arrangement without delay egress is used indicate in REMARKS 18.2.2.2.2, 19.2.2.2.2				
K44	Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5, 19.2.2.5				
K47	Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1				
	(Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)				

		Т		
ID PREFIX		MET	NOT MET	N/A
K72	Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1			
	ILLUMINATION			
K45	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8			
K46	Emergency lighting of at least 1½ hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.			
K105	2000 NEW (INDICATE N/A FOR EXISTING)			
	Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the Life Safety Branch of the electrical system described in NFPA 99. 18.2.9.2., 18.2.10.2 (Indicate N/A if life support equipment is for emergency purposes only).			
	EMERGENCY PLAN AND FIRE DRILLS	1	1	I
K48	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1			
K50	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2			

———ID			NOT		
PREFIX		MET	NOT MET	N/A	REMARKS
	FIRE ALARM SYSTEMS				
K51	A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6				
K52	A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,				
K155	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8				
K53	2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES) In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70				
	40 0700D (00 (0040)				Doge 16

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW (NURSING HOME AND EXISTING LIMITED CARE FACILITIES) An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridor.) Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.3				
K109	2000 EXISTING LIMITED CARE FACILITIES (INDICATE N/A FOR HOSPITALS OR NURSING HOMES)  An automatic smoke detection system is installed in all corridors with detector spacing no further apart than 30 ft on center in accordance with NFPA 72. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridors.) Such detectors are electrically interconnected to the fire alarm system. 19.3.4.5.1  Smoke Detection System  □ Corridors □ Rooms				
K54	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3  Give a brief description, in REMARKS of any smoke detection system which may be installed.				
K55	2000 EXISTING  Every patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8  2000 NEW  Every patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms				

ID		MET	NOT	N/A	REMARKS
PREFIX	intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8		MET		
(60	Initiation of the required fire alarm systems shall be by manual fire alarm initiation, automatic detection, or extinguishing system operation. 18.3.4.2, 19.3.4.2, 9.6.2.1				
	AUTOMATIC SPRINKLER SYSTEMS				
(56	2000 EXISTING				
	Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13				
	2000 NEW				
	There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1.				
(154	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1.				
	A. Date sprinkler system last checked and necessary maintenance provided				

		_		
ID PREFIX		MET	NOT MET	N/A
	B. Show who provided the service			
	C. Note the source of water supply for the automatic sprinkler system.			
	(Provide, in REMARKS, information on coverage for any non-required or partial automatic sprinkler system.)			
K61	Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72			
K62	Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5			
K63	Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13			
K64	Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6			
	SMOKING REGULATIONS			
K66	Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4, 8-6.4.2 (NFPA 99)			
	(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the internationa symbol for no smoking.			
	Exception: In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in use areas are not required. (Note: This exception is not applicable to medical gas storage areas.) 8-3.1.11.3 (NFPA 99)			

			1		
ID PREFIX		MET	NOT MET	N/A	REMARKS
	(2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision.				
	(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.				
	(4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.				
	BUILDING SERVICE EQUIPMENT				
K67	Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2				
K68	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2, 19.5.2.2.				
K69	Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96				
K70	Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 18.7.8, 19.7.8				
K71	Rubbish Chutes, Incinerators and Laundry Chutes. 18.5.4, 19.5.4, 9.5, 8.4, NFPA 82				
	(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with 9.5.				
	(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7.				
	(3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4.				

———ID			NOT		
PREFIX		MET	NOT MET	N/A	REMARKS
	(4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use.				
K160	2000 EXISTING				
	Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record.				
	Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators & Escalators. All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. 9.4.2, 9.4.3, 19.5.3				
	(Includes firefighters service <b>phase I</b> key recall and smoke detector automatic recall, firefighters service <b>phase II</b> emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
	2000 NEW				
	Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record.				
	New elevators conform to ASME/ANSI A17.1, Safety Code for Elevators and Escalators, including Fire Fighter's Service Requirements. 9.4.2, 9.4.3, 18.5.3				
	(Includes firefighters service <b>phase I</b> key recall and smoke detector automatic recall, firefighters service <b>phase II</b> emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
K161	2000 EXISTING				
	Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.				
	All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.2.2				
	·				, t

		1			
ID PREFIX		MET	NOT MET	N/A	REMARKS
	(Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.)				
	2000 NEW	1			
	Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.				
	All escalators and conveyors comply with ASME/ANSI A17.1, Safety Code for Elevators and Escalators. 18.5.3, 9.4.2.1				
	FURNISHINGS AND DECORATIONS				
<b>K73</b>	Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4				
<b>&lt;</b> 74	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13				
	□ Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2.				
	□ Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3				
	☐ Newly introduced upholstered furniture and mattresses means purchased since March, 2003.	3			
<b>K</b> 75	Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed .5 gal/ft² (20.4 L/m²). A	,			
	40 0700D (00/0040)		1		

ID PREFIX		MET	NOT MET	N/A	RE
THEID	capacity of 32 gal (121 L) shall not be exceeded within any 64-ft² (5.9-m²) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. 18.7.5.5, 19.7.5.5		IVIL I		
	LABORATORIES				
K31	Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard shall be protected in accordance with NFPA 99. (Laboratories that are not considered to be severe hazard shall meet the provision of K29.) 18.3.2.2, 19.3.2.2, Chapter 10 (NFPA 99)				
K136	Procedures for laboratory emergencies shall be developed. Such procedures shall include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with 10-2.1.3.1 (NFPA 99), 18.3.2.2., 19.3.2.1				
K131	Emergency procedures shall be established for controlling chemical spills in accordance with 10-2.1.3.2 (NFPA 99)				
K132	Continuing safety education and supervision shall be provided, incidents shall be reviewed monthly, and procedures reviewed annually shall be in accordance with 10-2.1.4.2 (NFPA 99).				
K133	Fume hoods shall be in accordance with 5-4.3, 5-6.2 (NFPA 99).				
K134	Where the eyes or body of any person can be exposed to injurious corrosive materials, suitable fixed facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. Fixed eye baths designed and installed to avoid injurious water pressure shall be in accordance with 10-6 (NFPA 99).				
K135	Flammable and combustible liquids shall be used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals.				

ID		MET	NOT	N/A	REMARKS
PREFIX		IVIEI	MET	IN/A	NEWANNS
	Storage cabinets for flammable and combustible liquids shall be constructed in accordance with NFPA 30, Flammable and Combustible liquids Code, 4-3 (NFPA 99), 10-7.2.1 (NFPA 99)				
	MEDICAL GASES AND ANESTHETIZING AREAS				
K76	<ul> <li>Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</li> <li>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</li> <li>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside.</li> <li>4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4</li> </ul>				
K77	Piped in medical gas, vacuum and waste anesthetic gas disposal systems comply with NFPA 99, Chapter 4.				
K78	<ul> <li>Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</li> <li>(a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others.</li> <li>(b) Relative humidity is maintained equal to or great than 35% 4-3.1.2.3(n) and 5-4.1.1 (NFPA 99), 18.3.2.3, 19.3.2.3</li> </ul>				
K140	<ul> <li>Medical gas warning systems shall be in accordance with NFPA 99, Standard for Health Care Facilities.</li> <li>(a) Master alarm panels are in two separate locations and have audible and visible signals.</li> <li>(b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4-3.1.2.2</li> <li>(c) Where a level 2 gas system is used, one alarm panel that complies with 4-3.1.2.2(b)3a,b,c,d and with 4-3.1.2.2(c)2,5 shall be permitted. 4-4.1 (NFPA 99) exception No. 4.</li> <li>4-3.1.2.2 (NFPA 99)</li> </ul>				
K141	Medical gas storage areas shall have a precautionary sign, readable from a distance of 5 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum:  CAUSION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99)				

	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.	MET	NOT MET	N/A	REMARKS
	NFPA 99, Standard for Health Care Facilities, Chapter 19.				
14440					
	Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows::  (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and  (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and  (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.  8-6.2.5.2 (NFPA 99)				
	ELECTRICAL AND EMERGENCY POWER				
	Hospitals and inpatient hospices with life support equipment have an Type I Essential Electric System, and nursing homes have a Type II ESS that are powered by a generator with a transfer switch and separate power supply in accordance with NFPA 99. 12-3.3.2, 13-3.3.2.1, 16-3.3.2 (NFPA 99)				
	Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1.4, 18.3.4.1, 19.3.4.1				
K108	2000 NEW (INDICATE N/A FOR EXISTING)				
	Power for Alarms, emergency communication systems, and illumination of generator set locations are in accordance with essential electrical system of NFPA 99. 18.5.1.2				
	Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)				
	The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99)				

ID			NOT		
PREFIX		MET	NOT MET	N/A	REMARKS
K146	The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source 3-6. (NFPA 99)				
K147	Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1				
K130	Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.				

### 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				
Surveyor (Signature)		Title	ffice	Date
Fire Authority Official (Signa	ature)	Title	ffice	Date

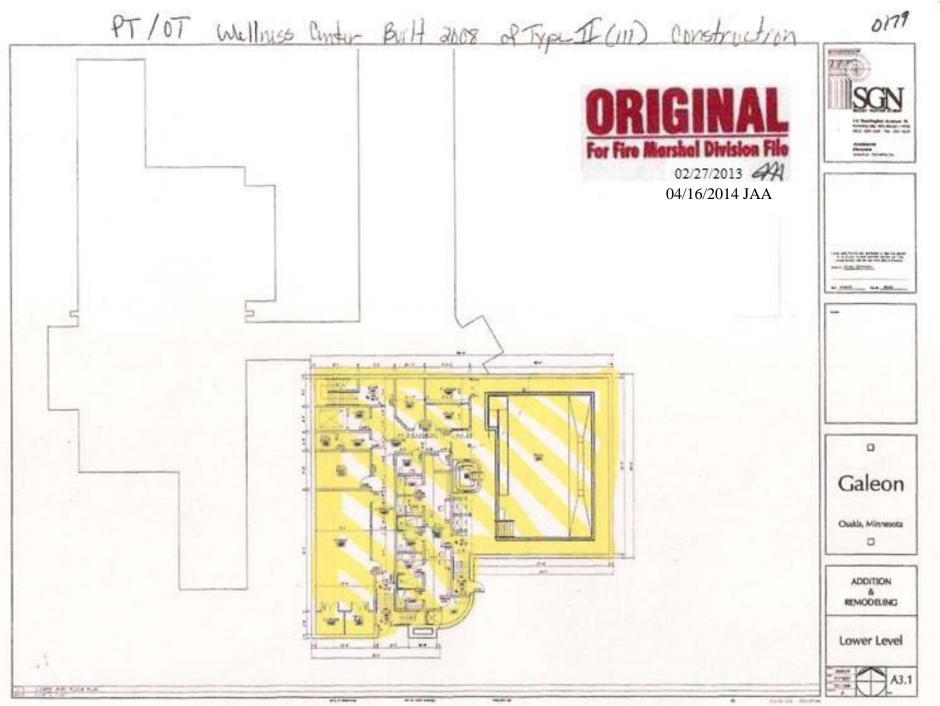
# FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS-2786 FORMS)

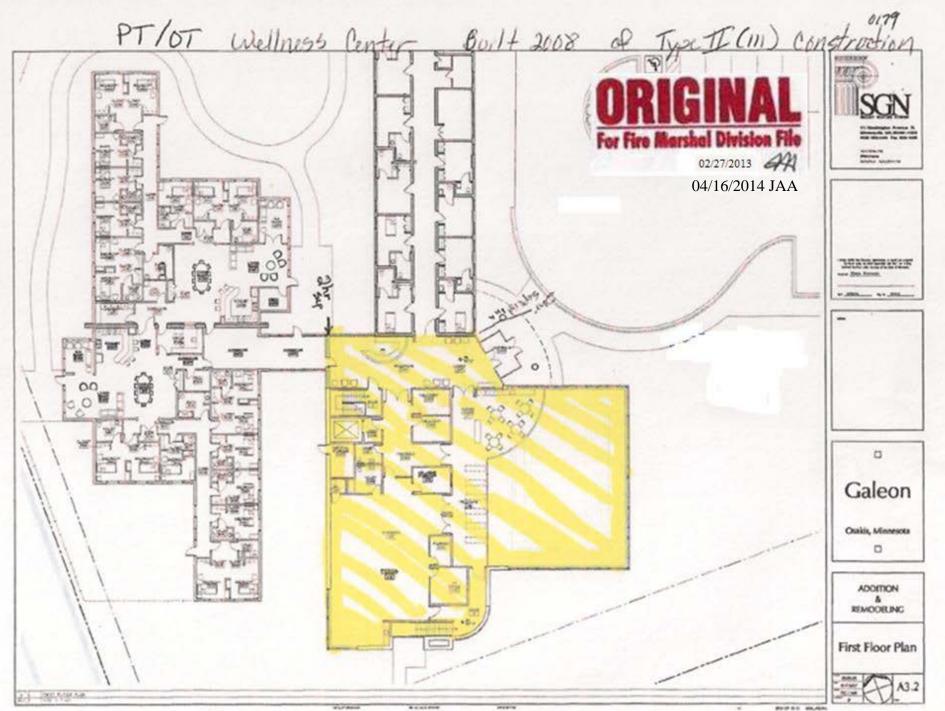
PROVIDER NUMBER	FACILITY NAME			SURVEY DATE
K1 245465	COMMUNITY MEMORIA	AL HOME		*K4 04/16/2014
K6 DATE OF PLAN APPROVAL	K3: MULTIPLE CONS TOTAL NUMBER OF BU NUMBER OF THIS BUIL	JILDINGS	2 A	A BUILDING B WING C FLOOR D APARTMENT UNIT
LSC FORM INDICATOR			PLETE IF ICF/MR IS SURVEYED UNDER	
Н	ealth Care Form	SMAI	LL (16 BEDS C	OR LESS)
12 2786 R	2000 EXISTING		1 PROMPT	
13 2786 R	2000 NEW		K8: 2 SLOW 3 IMPRAC	TICAL
	ACCE		3 IIVII KAC	TICAL
14 2786 U	ASC Form 2000 EXISTING			
15 2786 U	2000 EXISTING 2000 NEW	LARC	4 PROMPT	
13 27000	2000 NE W		K8: 5 SLOW 6 IMPR A C	TICAL
<del></del>	ICF/MR Form		6 IMPRAC	TICAL
16 2786 V, W, 2		_   _		
17 2786 V, W, 2	X 2000 NEW	APAR	TMENT HOUSE	
	F FORM USED FROM ABOVE		K8: 7 PROMP' 8 SLOW 9 IMPRAC	
2786 M, R, T, U, V, W, X, Y	narked as not applicable in the Y and Z.)	ENTE	ER E-SCORE HERE	
K29:	K56:		K5: e.g 2.5	
*K9 : FACILITY MEETS LSC B	ASED ON: (Check all that apply)	,		_
(COMP. WITH ALL PROVISIONS)	A2 X (ACCEPTABLE POC)	(WAIVERS)	A4 (FSES)	A5 PERFORMANCE BASED DESIGN)
FACILITY DOES NOT MEET LS B*MANDATORY	FUL	A. X  LY SPRINKLERED quired areas are sprinklered)	B.  PARTIALLY SPRINKLERED  (Not all required areas are sprinklered)	

# FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME		SURVEY DATE
K1 245465	COMMUNITY MEMORIAL HO	OME	*K4 <b>04/16/2014</b>
K6 DATE OF PLAN APPROVAL	K3: MULTIPLE CONSTRUCT TOTAL NUMBER OF BUILDING NUMBER OF THIS BUILDING	NGS 2 A	A BUILDING B WING C FLOOR D APARTMENT UNIT
LSC FORM INDICATOR		COMPLETE IF ICF/MR IS SURVEYED UNDER COMPLETE IF	
Не	ealth Care Form	SMALL (16 BEDS OR I	LESS)
12 2786 R	2000 EXISTING	1 PROMPT	
13 2786 R	2000 NEW	K8: 2 SLOW 3 IMPRACTIO	~AI
	ASCE	3 IIVII KACTIC	CAL
14 2786 U	ASC Form 2000 EXISTING	LARGE	
15 2786 U	2000 EXISTING 2000 NEW	LARGE 4 PROMPT	
13 2700 C	2000 NE W	K8: 5 SLOW	CAT
	CF/MR Form	K8: 6 IMPRACTIO	LAL
16 2786 V, W, X			
17 2786 V, W, X	2000 NEW	APARTMENT HOUSE	
	FORM USED FROM ABOVE	K8: 7 PROMPT 8 SLOW 9 IMPRACTION	CAL
(Cneck if K29 or K36 are m 2786 M, R, T, U, V, W, X, Y	arked as not applicable in the and Z.)	ENTER E-SCORE HERE	
K29:	K56:	K5: e.g 2.5	
*K9 : FACILITY MEETS LSC BA	ASED ON: (Check all that apply)		
A1 X  (COMP. WITH ALL PROVISIONS)	A2 (ACCEPTABLE POC)	A3 A4 (FSES)	A5 PERFORMANCE BASED DESIGN)
FACILITY DOES NOT MEET LS B. **MANDATORY	AFULLY SP	B. PRINKLERED PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	C. NONE (No sprinkler system)







Community Memorial Home - OSAICIS

Ainnesota 4 6 1	State Fire Marsh	nal Division-CMS Survey Draft Statemen	t of Deficiencies	J.	Page of
PROJEC	T NUMBER:	PROVIDER NAME			SURVEY DATE
Adminis	strator:		Phone Num	ber:	
Email a	ddress:				
State Fir	re Inspector:	2			The state of the s
	re preliminary f	findings only. A complete and final S	tatement of Deficiencie	s 2567 report w	vill be provided
Sat	fety Code appl	s inspection. this facility was found t licable to: SNF/NF Hospital Medicaid programs.			
☐ Th	e following fir	e/life safety deficiencies were fou	nd during this inspect	ion:	
K TAG S& S	☐ Draft	Summary of Deficiency(ies)	☐ Revisit	☐ Clea	arance

May 28, 2014

Mr. David Carlson, Community Memorial Home 410 West Main Street Osakis, MN 56360

Dear Mr. Carlson:

On 04/16/2014 a survey was completed at your facility. You have alleged that the deficiencies cited on that survey by the Minnesota Department of Public Safety, State Fire Marshal Division staff (K tags) have been, or will be corrected. We are accepting your plan of correction and presume that your facility will achieve substantial compliance.

Unless waivers have been recommended for all deficiencies cited, we will be conducting a revisit of your facility to verify that substantial compliance has been achieved and maintained.

Patrick Sheehan, Fire Safety Supervisor Deputy State Fire Marshal

State Fire Marshal Division 444 Cedar Street, Suite 145

1 Sheehar

St. Paul, Minnesota 55101-5145

Pat.Sheehan@state.mn.us

cc: Licensing and Certification File

Unit Supervisor

SFM File

# Sheehan, Pat (DPS)

From:

Sheehan, Pat (DPS)

Sent:

Friday, May 23, 2014 12:09 PM

To:

'rochi\_lsc@cms.hhs.gov'

Cc:

james.a.anderson@state.mn.us; 'Dave Carlson'; Dietrich, Shellae (MDH); 'Fiske-Downing,

Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen

(MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)

Subject:

Community Memorial Home (245466) 2014 K67 Annual Waiver Request - Previously

Approved - No Changes

This is to inform you that Community Memorial Home is again requesting an annual waiver for K67, corridors as a plenum. The exit date was 4-17-14.

I am recommending that CM approve this waiver request.

# Patrick Sheehan. Fire Safety Supervisor

Office: 651-201-7205 Cell: 651-470-4416 **Health Care & Corrections Fire Inspections** 

Minnesota State Fire Marshal Division 445 Minnesota St., Suite 145, St Paul, MN 55101-5145

FAX: 651-215-0525 Web: fire.state.mn.us

Community Memorial Home (CMH) at Osakis, MN Inc

# PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

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

as a plenum. the corridors are used 1999 Edition because 9.2 and NFPA 90A, with LSC (00) Section CMH does not comply and Air Conditioning **K**067 (HVAC) equipment at Heating, Ventilation PROVISION NUMBER(S) W A continuing waiver is being requested for K067 for the following reasons ⋗ An extreme financial hardship on Community Memorial Home(CMH) will result from compliance because: If this waiver is approved, the safety of building occupants will not be compromised because: 1. Revised estimates (5-14-14, attached) show that compliance with NFPA 90A will cost between CMH was built under Type II construction standards; CMH is completely protected by a supervised sprinkler system installed in accordance with NFPA 13; Walls, floors, ceilings and vertical openings at CMH already resist the passage of smoke Non-complying systems are allowed to be used under LSC(00), 9.2.1. HVAC ventilation fans automatically shut down upon activation of a fire alarm or upon detection of Asbestos abatement during installation would cost between \$59,483 and \$81,900; and The electrical system at CMH would need to be modified at a cost that may exceed \$42,000; \$446,120 and \$579,299. These dollars are not available under current reimbursement rules; JUSTIFICATION

Resident sleeping rooms are all equipped with single station battery operated smoke detectors

The property of CMH is smoke and tobacco free with signs posted to that effect:

All CMH Corridors are equipped with a compliant UL listed smoke detection system;

The local fire department is located 6 blocks away and can respond to an alarm in less than 10 mins.;

CMH has an approved fire safety plan and is compliant with all other fire safety requirements; and

A continuing warver has been approved annually in the past for Community Memorial. month 5-14-2014

Requested by: David E. Carlson, Administrator 5-14-2014

Surveyor (Signature)	Title		Office	Date
Fire Authority Official (Signature)	Title	Fire Safety Supervisor	Office <b>State Fire</b> Marshal	Date \$-25-14



PRELIMINARY MASTER BUDGET
Galeon - Community Memorial Home
PREPARED: 5/14/2014

3315 Roosevelt Road, Ste. 100 St. Cloud MN 56301

Bus. (320) 251-0262 Fax: (320) 251-5749

Low Range 24,000 S.F. High Range 24,000 S.F.

**DOLLARS** 

**DOLLARS** 

I. LAND	SUBTOTAL LAND	\$ P		\$	¥	
II. CONSTRUCTION COSTS						
GENERAL CONDITIONS		\$ 26,523	\$ 1.11	\$	32,448	\$ 1.35
INTERIOR FINISHES / DEMO	)	\$ 19,096	\$ 0.80	\$	29,203	\$ 1.22
MECHANICAL		\$ 203,693	\$ 8.49	\$	259,584	\$ 10.82
FIRE SPRINKLER	196	\$ 5,305	\$ 0.22	\$	10,816	\$ 0.45
ELECTRICAL		\$ 37,132	\$ 1.55	\$	43,264	\$ 1.80
CONTINGENCY	9	\$ 30,000	\$ 1.25	_\$_	38,000	\$ 1.58
SUBTOTAL CONS	TRUCTION COSTS	\$ 321,748	\$ 13.41	\$	413,315	\$ 17.22
III. SOFT COSTS						
FEES / PERMITS / PRINTING	3	\$ 64,890	\$ 2.70	\$	84,084	\$ 3.50
OTHER		\$ 	\$ 	\$	-	\$ -
SUBTO	OTAL SOFT COSTS	\$ 64,890	\$ 2.70	_\$_	84,084	\$ 3.50
IV. OWNER ITEMS						
FURNITURE/FIXTURES/EQU	JIPMENT	\$ ij		\$		
OTHER - ASBESTOS ABATE	MENT	\$ 59,483	\$ 2.48	_\$_	81,900	\$ 3.41
SUBTOTAL OW	NER ITEMS COSTS	\$ 59,483	\$ 2.48	\$	81,900	\$ 3.41
V. TOTAL PROJECT COST		\$ 446,120	\$ 18.59	\$	579,299	\$ 24.14