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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: 5L8E

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY** — Facility ID: 00109

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245465**

2.STATE VENDOR OR MEDICAID NO.
(L2) **668340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COMMUNITY MEMORIAL HOME**
(L4) **410 WEST MAIN STREET**
(L5) **OSAKIS, MN** (L6) **56360**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/05/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY ~~02~~ (L7)

| | | | | |
|---|---|---|---|---|
| 01 Hospital | 05 HHA | 09 ESRD | 13 PTIP | 22 CLIA |
| 02 SNF/NF/Dual | 06 PRTF | 10 NF | 14 CORF | |
| 03 SNF/NF/Distinct | 07 X-Ray | 11 ICF/IID | 15 ASC | |
| 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | |

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

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 50 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE — Date :
Marilyn Kaelke, HFE NE II — 07/18/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 09/12/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
**04/01/1987**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**06/20/2014**
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

***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.

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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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

**Post-Certification Revisit Report**



| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245465 | A. Building<br>B. Wing | 6/5/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET<br>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) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix **F0223**<br>Reg. # **483.13(b), 483.13(c)(1)(i)**<br>LSC | Correction Completed **05/16/2014** | ID Prefix **F0225**<br>Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)**<br>LSC | Correction Completed **05/16/2014** | ID Prefix **F0226**<br>Reg. # **483.13(c)**<br>LSC | Correction Completed **05/16/2014** |
| ID Prefix **F0250**<br>Reg. # **483.15(g)(1)**<br>LSC | Correction Completed **05/16/2014** | ID Prefix **F0280**<br>Reg. # **483.20(d)(3), 483.10(k)(2)**<br>LSC | Correction Completed **06/03/2014** | ID Prefix **F0282**<br>Reg. # **483.20(k)(3)(ii)**<br>LSC | Correction Completed **06/03/2014** |
| ID Prefix **F0309**<br>Reg. # **483.25**<br>LSC | Correction Completed **06/03/2014** | ID Prefix **F0490**<br>Reg. # **483.75**<br>LSC | Correction Completed **05/16/2014** | ID Prefix **F0520**<br>Reg. # **483.75(o)(1)**<br>LSC | Correction Completed **05/16/2014** |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | JS/KJ | 09/02/2014 | 27955 | 06/05/2014 |
| Reviewed By CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

| Followup to Survey Completed on: | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? | YES | NO |
|---|---|---|---|
| 4/17/2014 | | | |

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

Form Approved
OMB NO. 0938-0390

**Post-Certification Revisit Report**



| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245465 | A. Building B. Wing **01 - MAIN BUILDING 01** | 7/18/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET<br>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) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix | Correction Completed **07/17/2014** | ID Prefix | Correction Completed **07/17/2014** | ID Prefix | Correction Completed **07/17/2014** |
| Reg. # **NFPA 101** | | Reg. # **NFPA 101** | | Reg. # **NFPA 101** | |
| LSC K0011 | | LSC K0018 | | LSC K0050 | |
| ID Prefix | Correction Completed **07/17/2014** | ID Prefix | Correction Completed **07/17/2014** | ID Prefix | Correction Completed **07/17/2014** |
| Reg. # **NFPA 101** | | Reg. # **NFPA 101** | | Reg. # **NFPA 101** | |
| LSC K0052 | | LSC K0062 | | LSC K0144 | |
| ID Prefix | Correction Completed | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. # | | Reg. # | | Reg. # | |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction Completed | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. # | | Reg. # | | Reg. # | |
| LSC | | LSC | | LSC | |
| ID Prefix | Correction Completed | ID Prefix | Correction Completed | ID Prefix | Correction Completed |
| Reg. # | | Reg. # | | Reg. # | |
| LSC | | LSC | | LSC | |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | PS/KJ | 09/02/2014 | 27200 | 07/18/2014 |
| Reviewed By CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

| Followup to Survey Completed on: | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO |
|---|---|
| 5/15/2014 | |

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: 5L8E

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY** — Facility ID: 00109

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245465**

2.STATE VENDOR OR MEDICAID NO.
(L2) **668340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COMMUNITY MEMORIAL HOME**
(L4) **410 WEST MAIN STREET**
(L5) **OSAKIS, MN** (L6) **56360**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/17/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

| | | | | |
|---|---|---|---|---|
| 01 Hospital | 05 HHA | 09 ESRD | 13 PTIP | 22 CLIA |
| 02 SNF/NF/Dual | 06 PRTF | 10 NF | 14 CORF | |
| 03 SNF/NF/Distinct | 07 X-Ray | 11 ICF/IID | 15 ASC | |
| 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | |

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

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 50 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE — Date :
LoAnn DeGagne, HFE NE II — 06/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 06/19/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
**04/01/1987**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

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

30. REMARKS
AW K67 Emailed CMS 06/20/2014 Co.
Posted 06/20/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*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:

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

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

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

**Substandard Quality of Care - 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;**

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

**Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and**

**Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.**

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

## 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
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,

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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| F 000 | INITIAL COMMENTS<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance.<br><br>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.<br><br>A recertification survey was conducted by the Minnesota Department of Health on April 14th, 15th, 16th and 17th, 2014. The survey resulted in an Immediate Jeopardy (IJ) at F223 related to the facility's failure to ensure residents who were resistive with cares were free of staff abuse which resulted in the high potential for harm or death. Facility staff were notified of the IJ on April 15, 2014, at 4:47 p.m., which began on April 15, 2014. The IJ was removed on April 17, 2014, at 4:20 p.m., however, non-compliance remained at the lower scope/severity of an E, pattern with potential for harm. An extended survey was completed on April 16th and 17th, 2014. | F 000 | | |
| F 223 SS=K | 483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION<br><br>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.<br><br>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. | F 223 | accepted 6/3/14 Jen Stelmo | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David E. Carlson, TITLE: Administrator (X6) DATE: 6-3-14

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

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| F 223 | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure 4 of 4 residents, (R44, R50, R34, and R53) who exhibited combative behaviors were not physically abused when the resident(s) were restrained by staff providing necessary cares. The failure of the facility to ensure combative residents were assessed, interventions developed/monitored to ensure appropriate interventions were in place and were implemented by staff, the lack of investigation and oversight of staff who acknowledged restraining residents while providing personal cares, which resulted in bruising to residents, resulted in an immediate jeopardy for R44, R50, R34, and R53. These residents were identified by staff as residents who were combative with cares and as a result staff restrained them.<br><br>The immediate jeopardy began on 4/15/14, at 4:47 p.m. when the facility failed to comprehensively assess, investigate, and implement interventions to ensure combative residents were not restrained or injured by staff during the performance of personal cares. The administrator and director of nursing (DON) were notified of the immediate jeopardy (IJ) for R44, R50, R34, and R53 on 4/15/13, at 4:47 p.m. The IJ was removed on 4/17/13, at 4:20 p.m. but noncompliance remained at a pattern scope and severity level, with potential for actual harm.<br><br>Findings include:<br><br>R44's admission record identified diagnoses | F 223 | F223 Plan of correction 5/16/14<br><br>Resident 44, 50, 34, and 53 were assessed for bruising on 4/16/14 which was not correlated to any documented incidents. No injuries were noted on residents 44 and 53. Bruising, not correlated with an incident was located on resident 50 and 34 which were immediately filed to OHFC after the facility administrator was updated.<br><br>All residents in the facility were 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 higher risk of obtaining injury related to their combative and aggressive behaviors. These 4 other residents were also | |

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| F 223 | Continued From page 2<br>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.<br><br>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 related to combative behavior. LPN-C stated at times it took up to 3 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" on R44 to quickly "get the cares done" because it was difficult to redirect the resident once she became agitated.<br><br>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 5:35 p.m. R44 was in the dining room being assisted by a [unknown] nursing assistant (NA) and was cooperative.<br><br>R44's care plan, last updated on 1/24/14, | F 223 | assessed on 4/16/14 for injuries which were not documented in an incident report. No new or unexplained injuries were noted.<br><br>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 reviewed and updated on 4/16/14 to include a more focused "behavior plan". This plan has resident specific interventions for the direct care staff to use when/if the resident displays aggressive behaviors.<br><br>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 residents in the facility will have weekly skin audits done starting the week of 4/21/14 for 60 days to assure that all residents are | |

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| F 223 | Continued From page 3<br>identified the resident had behaviors, which included her restiveness with personal cares and could become physically and verbally aggressive. She also had a history of striking out at staff during personal cares. The interventions directed staff, " ...when doing cares, check/ change in bed; may work better if one person holds her hands and engages her with explanations/ soothing words/ conversation to distract from the cares..."<br><br>On 4/14/14, the facility provided R44's injury reports from January 1, 2014, to present time. The DON reported all injury reports prior to January 1, 2014 had been shredded and therefore not available.<br><br>An injury report dated 1/10/14 indicated R44, "...was combative with HS [hour of sleep] cares noted to have grabbed staffs wrist. Staff stated, 'She grabbed my wrist with my watch on it. When I pulled my arm out her grasp and looked the top of her hand was bleeding noted resident to have an abrasion to the top of her right hand...' wound cleansed, 3 steri strips and bacitracin applied, and wrapped with cling wrap." No further investigation was found regarding the incident or evidence of further assessment/additional interventions being implemented.<br><br>An injury report dated 2/13/14, identified R44 "...cares were being performed and resident swung arm at staff running right hand across nametag of staff and obtained a 1.7 x 1.7 abrasion to top of right hand... wound cleansed, bacitracin and gauze applied, will continue to monitor daily." No further investigation was found regarding the incident or evidence of further assessment/additional interventions being implemented. | F 223 | being monitored for unknown injuries. In addition to skin audits, the 8 residents above which were determined to be at risk for injury are being audited twice weekly during ADL cares to monitor the direct care staff and resident interaction while cares are being provided. These ADL care audits will continue twice weekly for 30 days from 4/21/14 and then weekly for the following 30 days. Any bruising or injury found will be followed up on and investigated by licensed staff to assure that the resident is free from abuse.<br><br>The Accident/Injury policy and procedure will be followed and a vulnerable adult will be submitted if the injury is from an unknown cause or abuse. | |

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| F 223 | Continued From page 4<br><br>An injury report dated 3/2/14, indicated R44, "...had incontinent BM [bowel movement] and was combative with AM [morning] cares. Was hitting out at staff. Staff was holding onto her hands to prevent her from digging into BM and striking out at staff. At lunch bruises were noted. Resident was unaware." A wound assessment/ monitoring form dated 3/2/14, identified R44 had left wrist bruising which measured 3.5 cm (centimeter) x 5.2 cm and right wrist bruising which measured 3.6 cm x 2.8 cm. The assessment indicated the specific interventions being used were, "Try to calm and reapproach resident when combative." No further investigation/interventions were found.<br><br>An injury report for R44 dated 3/14/14, indicated " ...When NA [nursing assistant] were assisting resident with her A.M. cares they noted resident to have 2 bruises to her left forearm. Author observed bruises to be dark purple in color measuring 6 cm x 3 cm and 3 cm x 3 cm. NOC [night] nurse reported resident was very combative during cares and hitting staff with her hands and arms. Is likely bruising is from residents combativeness." No further investigation was found regarding the incident or evidence of further assessment/additional interventions being implemented.<br><br>A review of R44's progress notes from 9/13- present was completed and the following were noted:<br>9/11/13- "Resident had an abrasion to left forearm. NA noticed abrasion during HS cares. Inside of residents left sleeve noted to have old dried blood as well. Author observed a wide C shaped abrasion covered in moderate amount of | F 223 | As of 5/16/14, all nursing staff have been assigned two education sessions called "Abuse Prevention In Persons with Dementia: The Basics" and "Client Behaviors: Assessment and Intervention in the Resident with Dementia" from the online education system, "Healthcare Academy". The staff have until June 6th, 2014 to complete the required education courses until discipline is enforced by administration.<br><br>The following system changes have taken place since 4/16/14- A new facility 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 | |

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| F 223 | Continued From page 5<br>old dried blood. On lateral side of arm near abrasion contains a blue/ dark purple hematoma. Resident unable to describe what happened ... abrasion measuring 4.5 cm x 0.8 cm. Hematoma approximately 5 cm x 3 cm x 1 cm." There was no further investigation or explanation of this injury found in the medical record.<br>10/3/13- "Occasional episodes of combative behavior are effectively managed by nursing home staff as per POC (plan of care)."<br>10/8/13- "RN manager reports some combative behaviors during PM cares ..."<br>11/5/13- "...is still intermittently combative with care, most at HS."<br>11/25/13- "...combative with HS cares but nothing unusual ..."<br>12/25/13- "... was combative with cares. Assist of 3 to provide HS cares and assist into bed ..."<br>12/27/13- " ... has been very combative and resistive this shift ..."<br>1/5/14- " ...Resident was hitting and pinching staff with peri cares this AM."<br>1/10/14- " Resident was combative with HS cares ..."<br>2/19/14- " ...was combative with AM cares today. She was combative again this afternoon, scratching a staff member's wrist. "<br>3/3/14- "...staff report increased hitting out behaviors. Both forearms badly bruised. She states she doesn't remember how it happened. "<br>3/7/14- " Combative with 10:00 p.m. rounds, verbal with HS rounds. Redirected behavior with minimal success."<br>3/10/14- ..."resident did become combative and pinched NA during brief change during the night. Resident is usually resistive/combative with brief changes during the night shift ..."<br>3/12/14- " ...noted to be combative and have verbal outbursts during HS cares." | F 223 | administrator Monday through Friday and daily by an RN. The administrator is notified immediately of any incidents which are VA reportable per Vulnerable Adult Policy and Procedure on all days of the week including weekends. On 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 by the DON on 4/16/14 to include the addition of individualized "behavior plans" which will be put into place if a resident is at risk of injury related to aggressive behaviors. These resident specific behavior plans will be reviewed with residents and their families during scheduled care conferences to assure that all interventions in place are beneficial, appropriate and agreed upon by both staff and | |

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| F 223 | Continued From page 6<br>3/13/14- "...noted to be combative and have verbal outbursts during HS cares. Was also combative during night every 2 hour rounds."<br>3/14/14- " ...combative and have verbal outbursts during HS cares ..."<br>3/16/14- " ...Combative with HS cares ... was combative hitting, scratching, pinching and attempting to bite at staff during 10:00 p.m., midnight, 2:00 a.m., and 4:00 a.m. cares...."<br>3/19/14- " Combative and agitated with NA assisting her with HS cares. Was compliant and cooperative with author. Author excused NA from the room and finished assisting resident with HS cares ..."<br>4/3/14- " ...There has been no significant improvement with her behaviors with the increase [in anti-psychotic medication]. She continues to be combative with most personal cares, and is not redirect able with this. Change in caregiver may be helpful, at times not."<br>Although R44's progress notes identified the resident was consistently combative with staff while providing cares which resulted in the resident receiving bruising, the facility was unable to provide any investigation, tracking, or any assessments completed regarding R44's combative behaviors or staff interventions being used to ensure interventions were appropriate and being implemented.<br>During an interview on 4/15/14, at 9:05 a.m. NA-A reported R44 was combative when staff is providing cares. NA-A indicated it would often take 3 staff to change R44's brief, however, the resident was "smaller" so it can often be done with 2 staff; one staff to change the resident's brief and one to hold her hands down to prevent the resident from hitting staff or herself. NA-A also reported that if R44 needed cares provided it worked best if " we just try to get her changed | F 223 | residents/families. On 4/17/14 the DON, Administrator and LSW reviewed the facility Vulnerable Adult Policy and Procedure and made multiple changes which include the addition of reference checks, suspension for employees under investigation by DHS, training of new employees with a focus on Alzheimer's/dementia care, staff burnout, and supportive care of the residents during 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 all incidents | |

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| F 223 | Continued From page 7<br>and get it over with."<br>During an interview on 4/15/14, at 9:35 a.m. NA-D indicated R44 was combative with staff when they are providing cares to her (the resident). NA-D reported R44 only required one staff assist with cares, but usually 2 staff were required to help so one staff can "hold the resident's hands down when cares are being done." NA-D stated she knew staff had caused bruising to R44's wrists, arms, and ankles from holding them down when staff were trying to get personal cares done, but "the residents" are so resistive and staff are just trying to get the residents cares done as quickly as possible. NA-D indicated she felt "horrible" when residents had developed bruising from holding them down to perform cares, but she stated, "They are just so fragile and struggling with us so much when we are holding them." NA-D stated about a month ago R44 needed to have her brief changed and was resistive. NA-D stated staff had to hold the resident's wrists/ hands so the resident could be cleaned up. NA-D reported about 2-3 hours later staff observed R44's wrists were bruised "like perfect hand prints." NA-D stated that made her feel "horrible."<br><br>R50's admission MDS dated 2/18/14, indicated diagnoses that included arthritis, dementia, dysthymic disorder and a history of transient ischemic attacks (TIAs), severe cognitive impairment, required extensive assistance with all ADL's, and rejected care 4-6 days of the 7 look back assessment period. R50's CAA dated 2/18/14, identified resident, "Has dementia, that has progressed to where she is essentially nonverbal, dependent upon staff for ADL's. She is unable to express her needs, and staff needs to anticipate/ be aware of nonverbal indicators. | F 223 | need to be thoroughly 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 Adult report will be submitted immediately.<br><br>Risk meetings will be held monthly starting in May 2014, and will have a focus on reviewing incidents/accidents and individual resident care plans to address behavior plans and interventions. This meeting will continue indefinitely. Any noted trends will be thoroughly reviewed by the team and brought forth and discussed during the facility's QA&A meetings.<br><br>The corrective action for F223 was completed on 5/16/14. | |

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| F 223 | Continued From page 8<br>She is still able to propel her wheelchair, and does so aimlessly about the facility. She is combative with cares, and may act out towards others near her- especially if in the path of where she is going. This puts her at risk for injury for self or others." However, the CAA failed to comprehensively assess R50's ongoing behaviors and to ensure interventions were in place related to R50's behaviors to direct staff on how to provide cares to the resident.<br><br>R50's care plan updated 4/14/14, identified the resident was resistive with cares, wandered, verbal and physical resistance with cares, and may reach out and grab at other people in her path. The interventions included allow time for thought process when providing cares, keep her warm during cares, and attempt to distract with music or items to manipulate her hands.<br><br>During observation on 4/15/14, at 6:30 p.m. R50 was observed in the bird room and was pinching another resident (R34) in the upper left arm. R34 repeatedly said, "Stop, get the hell out of here!" With no communication to R50, an [unknown] staff member grabbed the back of R50's wheelchair and pulled her backwards out of the bird room into the hallway. The resident was left sitting in the hallway alone.<br><br>On 4/14/14, the facility was asked to provide R50's injury reports from January 1, 2014 to present. The DON indicated R50 had no injury reports/ investigations during that time period.<br><br>A review of a Wound Assessment/ Monitoring form, dated 4/3/14, identified R50 had left forearm bruising measuring approximately 6 cm in length and 1 cm wide; reddish/ purple in color. | F 223 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 223 | Continued From page 9<br>No investigation was found regarding the bruise of unknown origin or any further assessment/ care plan revisions.<br><br>Review of R50's progress notes identified the following:<br><br>2/12/14- "Not alert or orientated x 3 or able to communicate needs...Combative with HS cares, not able to redirect."<br><br>2/13/14- "Combative with HS cares."<br><br>2/13/14- "In AM she was noted to be verbal and combative... 2 assist with cares due to being combative..."<br><br>2/15/14- "NAs noted resident to be combative with HS cares."<br><br>2/16/14- "NAs noted resident to be combative with HS cares."<br><br>2/16/14- "Resident very combative this morning with AM cares; would hit out and pull staffs hair. When up has been scooting around facility in wheelchair and runs into other residents and walls continuously."<br><br>2/17/14- "Hit at staff with each attempt [at care]. NAs noted resident to be combative with HS cares."<br><br>2/18/14- "Combative throughout shift, hitting, pinching, and squeezing arms of personnel."<br><br>2/18/14- "During AM cares resident was noted to be combative towards NA. NA explained each task before and during, this did improve | F 223 | | |

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 223 | Continued From page 10<br>behaviors."<br><br>2/21/14- "was combative and verbal with AM cares... has been wandering in halls and running her wheelchair into residents, staff, and other objects."<br><br>2/22/14- "Combative with AM cares."<br><br>2/24/14- "Wheeling into other resident's wheelchair in bird room... hitting out at staff during HS cares. Resistive with cares, grabbing clothes, wash cloth, towel and bedding."<br><br>2/25/14- "Running into other resident's wheelchairs and also wandering into other residents rooms... combative during HS cares. Also combative while being repositioned on rounds during the night."<br><br>2/26/14- "Combative with reposition during the night."<br><br>2/27/14- "Found in other resident's rooms. Was also running into other resident's wheelchairs. NAs noted resident to be very combative during HS cares."<br><br>3/2/14- "Combative with cares... was found to be wandering into other resident's rooms. Redirected with some results."<br><br>3/3/14- "Resident was noted to be wandering through the facility at the beginning of the shift. Was found multiple times in other residents' rooms, digging in drawers, garbage... She was also noted multiple times to be running into other residents' wheelchairs, squeezing fellow resident's leg- staff had to remove her hand. | F 223 | | |

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 223 | Continued From page 11<br>Staff attempted redirecting resident multiple times during PM shift- all attempts failed. Noted to be very combative during HS cares."<br><br>3/4/14- "Noted to be wandering in and out of other resident rooms. Combative with HS cares. Noted to be hitting out at staff during HS cares. Resistive... Staff explained procedure to her, and she continued to be resistive and combative. Total assist of 2..."<br><br>3/5/14- "Wanders into other resident's rooms. Does not leave other residents' rooms even if being yelled at by that resident. Several attempts were made by staff to redirect, without success... combative and resistive with staff during HS cares."<br><br>3/14/14- "Has been noted to be combative with cares in AM."<br><br>3/15/14- "Grabbed another resident in the chest. Staff assistance required to get her to let go."<br><br>3/16/14- "Was observed by staff that she had grabbed another resident in the chest. Attempting to hit another resident. Author stopped her as she was about to run another residents feet over with her wheelchair. Aggressive with HS cares."<br><br>4/3/14- Resident "is combative with her personal cares, wanders throughout the building in her wheelchair; difficult to redirect."<br><br>4/13/14- "Irritable, striking out when approached to change her direction or remove from other resident areas. Striking out at those she was near..." | F 223 | | |

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 223 | Continued From page 12<br><br>Although the review of the progress notes in R50 medical record indicated consistent ongoing documentation of R50's restiveness with personal cares, there was no further investigation, tracking, or assessment of these combative behaviors to ensure appropriate interventions are in place.<br><br>During interview on 4/15/14, at 9:05 a.m. NA-A stated R50 is combative "all the time" when staff is attempting to provide cares to the resident. She stated when providing cares to R50 it requires 2 staff, one to provide the cares, and one to hold the resident's hands and feet so cares can be provided. NA-A stated she reported R50's behavior to the nurse "every day," but she does not know what the nurse did with the information as the resident's combative behavior never improved.<br><br>During interview on 4/15/14, at 9:35 a.m. NA-D reported R50 was combative "all the time" with "any cares" staff attempted to provide. NA-D also reported staff tried to redirect the resident by talking with her, but R50 could not be redirected. NA-D stated sometimes it takes 3 staff to change the residents brief because the resident is "pretty big and strong." She stated the resident's bed was against the wall and one staff stands above R50's head to hold her arms down, and the other two staff get the resident's cares done. NA-D stated, "We have to hold her down to get her cares done or we would never get done." NA-D stated she reports this to the charge nurse "all the time" but nothing is ever done to help caring for R50 any easier. NA-D stated, "I know it isn't right [to hold residents down]; but how else do you do cares?" | F 223 | | |

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 223 | Continued From page 13<br>R34's quarterly MDS dated 2/13/14, identified the resident had diagnoses that included peripheral vascular disease, dementia and anxiety disorder. She had moderate cognitive impairment, required extensive assistance with ADLs, and rejected care 1-3 days of the 7 day look back assessment period. R34's CAA dated 11/21/13 identified the resident, "Has diagnosis of dementia with behaviors. She is alert, orientated to self, recognizes staff, facility locations. She is unaware of time of day, month. She is easily/ quick to have mood changes from pleasant to angry and reverse. She does have a hearing deficit with hearing aids which she refuses to wear (similarly her glasses's) which could impact her interpretation of her surroundings. At risk for isolation, misunderstandings." However, the CAA failed to comprehensively assess R34's ongoing behavior to ensure interventions were in place related to R34's behaviors to direct staff on how to provide cares to the resident.<br><br>R34's care plan dated 2/27/14, identified the resident is verbally aggressive and resistive to cares. Staff were instructed to reapproach with different staff if resident was refusing cares, report to nurse cause and effect relationship when behavior is exhibited, assure good communication was maintained and resident understands what was happening, and set limits for behavior with resident. If non-compliant and safe, staff were directed to leave situation until behavior stops. They were to reapproach later and "verbally demand behavior stop."<br><br>During an observation on 4/15/14, at 6:30 p.m. R34 was seated in her wheelchair in the bird room. Another resident (R50) wheeled next to | F 223 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 223 | Continued From page 14<br>her and began pinching her in the upper left arm. R34 kept saying, "Stop, get the hell out of here!" A [unknown] staff member grabbed the back of R50's wheelchair and pulled her backwards out of the bird room into the hallway. R34 was left sitting in the bird room and was not approached by staff to ask the resident what happened or if she had any injuries.<br><br>On 4/14/14, the facility provided R44's injury reports from January 1, 2014, to present time. The DON reported all injury reports prior to January 1, 2014, had been shredded and therefore not available.<br><br>An injury report dated 1/20/14, indicated, "Noted to have bruising to bilateral arms and wrists, has had increased physical behaviors with staff during cares, including hitting at staff and hitting PAL lift with fists, bare hands typically during cares and transfers. The immediate action taken was, "Monitor bruising until healed. Leave and re approach when angry with cares." There was no further investigation of this incident nor was there any identification of which staff had been caring for the resident.<br><br>Review of R34's Wound Assessment Monitoring identified the following:<br><br>12/28/13- Right forearm bruising 3.5 cm x 2.3 cm. Right forearm bruising 9.5 cm x 5 cm x 0.2 cm [depth]. The monitoring form identified the bruising was dark purple. There was no further assessment or investigation regarding the bruising.<br><br>1/6/14- Multiple bruising to left arm. Bruising to left hand [back] measuring 4 cm x 6 cm. The | F 223 | | |

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 223 | Continued From page 15 | F 223 | | |

appearance indicated, "Bruising to hand and multiple to left arm. Bruises are dark blue/ purple in color. Discontinue mobility bars in bed. Resident may be bumping her arms on these."

1/11/14- Right forearm bruising. "Dark purple around the edges of bruising. Appears to be fading in the middle. Yellow color to middle of bruise." There was no further investigation or explanation of the bruising.

1/20/14- Left back hand bruising and left arm bruising. "Has one penny sized bruise present on the left hand and has multiple bruises present on her forearm." There was no further investigation or explanation of the bruising.

Review of R34's progress notes revealed the following:

12/23/13- "Had one brief episode of verbal and physical behaviors during AM cares."

1/4/14- "Was rude and combative with cares this AM. She grabbed one of the staff's hair when being assisted to the bathroom."

1/15/14- "Resident noted to be very verbal and combative with staff this shift. Hitting, kicking, and scratching staff during HS cares. Also calling staff inappropriate names and swearing at them. Resistive with transfers during HS cares.

1/17/14- "...noted to be hollering out/swearing at staff. Was noted to be slapping, pinching, reaching out, and punching at staff, as well as PAL lift. Continues with multiple bruises to forearms and hands..."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 223 | Continued From page 16<br>1/22/14- "Resident noted to both verbal and physical with staff throughout shift... was also hitting with HS cares and during [night] every 2 hour rounds."<br><br>1/25/14- "...was verbal and combative with her AM cares..."<br><br>2/4/14- "... very resistive and physical with cares this shift. Both HS cares and [night] rounds. Was noted to be hitting at/ slapping staff..."<br><br>2/6/14- Resident "verbal and combative at start of shift. Yelling 'bitch; your stupid; just go to hell.' Combative with HS cares."<br><br>2/16/14- "Resident noted to be verbal and combative with HS cares... Also hit at staff while being repositioned during [night] every 2 hour rounds."<br><br>2/20/14- "Verbal and combative with HS cares. Hit and yelled at staff while being repositioned during [night] every 2 hour rounds."<br><br>2/21/14- "Combative with AM cares this morning."<br><br>2/27/14- "Verbal towards other residents and staff throughout shift. Was also combative during repositioning during the night..."<br><br>3/13/14- "During toileting this AM resident sustained a small abrasion to the left rear thigh." There was no further assessment or investigation of how the abrasion happened.<br><br>Although R34's progress notes identified the resident was consistently combative with staff while providing cares which resulted in the | F 223 | | |

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 223 | Continued From page 17<br>resident receiving bruising, the facility was unable to provide any investigation, tracking, or assessments related to R34's combative behaviors or staff interventions being used to ensure interventions were appropriate and being implemented.<br><br>During interview on 4/15/14, at 8:50 a.m. LPN-C reported R34 was combative with cares. LPN-C stated staff would sometimes try to reapproach the resident later to provide cares, but, if that didn't work, it would take an extra staff to assist with holding the residents arms and legs to provide the cares. LPN-C indicated often holding R34's arms and legs down was the only way to get cares done on the resident.<br><br>During interview on 4/15/14, at 9:05 a.m. NA-A stated R34 is often combative with cares. NA-A stated it will often take "a few of us" to provide cares because one has to "hold her hands" while the other staff is providing the cares. NA-A stated R34 is very combative when males provide cares because she doesn't like men to take care of her.<br><br>R53's annual MDS, dated 1/9/14, identified resident diagnoses that included dementia with behavioral disturbance, benign prostatic hyperplasia, cerebrovascular accident, depression and psychophysical visual disturbance. The resident had moderate cognitive impairment, required extensive assistance with ADLs, and rejected care 1-3 days of the 7 day look back assessment period. R53's CAA dated 1/9/14, identified the resident, "Has diagnosis of dementia, complicated with history hallucinations, paranoia. He is aware of his location, recognizes family, his judgement and reasoning are | F 223 | | |

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 223 | Continued From page 18 | F 223 | | |

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 reason...not 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.

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 223 | Continued From page 19<br><br>On 4/14/14 the facility provided R53's injury reports from January 1, 2014, to present. The DON stated injury reports prior to January 1, 2014 had been destroyed.<br><br>The facility provided one injury report for R53 dated 3/2/14, with a revision date of 4/14/14, which identified the resident was "Combative with HS cares, to thrashing arms in PAL. Abrasion noted to left arm after HS cares completed... Checked PAL and bed for sharp edges." A Wound Assessment and Monitoring Report identified R53 had (2) left antecubital (forearm) abrasion(s) measuring 1.3 cm x 0.7 cm and 1 cm x 0.3 cm. The interventions listed were, "Check for any sharp edges."<br><br>Review of R53's Progress Notes from 12/1/13 to present identified the following:<br><br>1/14/14- "Resident noted to be hitting another resident in the back of the head today, NA quickly removed [R53] from room and told him this behavior was inappropriate."<br><br>1/20/14- "Behaviors have improved from the very resistive, paranoid, yelling. He continues to refuse cares, be irritable but there is the possibility of getting him distracted or talked into the task you wish him to do..."<br><br>2/10/14- "Noted to be sitting in the TV room with other residents. Staff heard another resident hollering out for help. When staff approached the TV room, resident was noted to be holding on the back of the other resident's wheelchair and preventing her from leaving the area. Took several attempts to redirect resident before he let | F 223 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 223 | Continued From page 20<br>go of the wheelchair... When staff attempted to reposition resident he became resistive and hollering. Also was noted to be combative and pulled female NA's hair. Resident was not redirectable or able to be distracted."<br><br>3/5/14- "Was resistive with HS cares."<br><br>3/20/14- "Noted to be combative and resistive during HS cares." This was the last documented note regarding the resident being resistive with cares.<br><br>Although R53's progress notes identified the resident was combative with staff while providing cares which resulted in the resident receiving bruising, the facility was unable to provide any investigation, tracking, or assessment related to R53's combative behaviors or staff interventions being used to ensure interventions were appropriate.<br><br>During interview on 4/15/14, at 9:35 a.m. NA-D stated R53 was combative with cares and "just about anytime you try to do something with him." NA-D also reported two staff can usually "handle him," but if he was combative staff try to walk away and reapproach him later. NA-D indicated if staff comes back and R53 was still combative, staff would need to restrain him [hold his hands/ legs] to do cares. NA-D stated, "We do what we have to do" to complete cares.<br><br>During interview on 4/15/14, at 8:50 a.m. LPN-C stated if a resident was noted with bruising she would ensure the bruising was monitored to ensure healing. LPN-C stated she was aware staff needed to hold combative residents down to provide cares and was aware bruising had | F 223 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 223 | Continued From page 21 | F 223 | | |

resulted from staff restraining residents. LPN-C stated she did not think the bruising required investigation or reporting because she was aware the bruising was related to the resident being combative while staff was assisting the resident with cares. LPN-C stated an injury/ incident report is not always filled out for bruising, especially if it was known where the bruising came from.

During interview on 4/15/14, at 12:10 p.m. DON stated she was aware staff needed to restrain combative residents to do personal cares. The DON stated if a resident was combative or resistive with cares staff should leave the resident safe, and reapproach. DON stated, "The cares have to get done for these resident's and there are just some resident's who are difficult." She stated when a resident had dementia, there was a risk the resident may be resistive with cares and staff needs to get "cares done as quickly as possible for these residents, you can't just leave them in a soiled brief and not get cares done." DON stated, "There is a point we have to provide cares and I know that residents are held down by staff to provide the needed cares." DON stated staff were restraining resident's for their own safety to make sure the resident's were not striking staff or injuring themselves. DON verified injury reports of bruising were documented at times for some residents as related to "combative with cares." She stated this bruising was not suspicious and did not require a full investigation because the facility was aware where the bruising came from and knew the residents weren't being abused. The DON verified the facility did not complete assessments on residents with behaviors or who were combative with cares to ensure individualized interventions were in place;

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 223 | Continued From page 22<br>nor did the facility have any investigations or tracking of staff who were providing cares to the residents when they were combative with cares and received bruises. DON stated she never considered the residents were being abused as she felt the staff were doing their best to care for the difficult residents.<br><br>During interview on 4/16/14 at 1:30 p.m.,facility administrator stated he was not aware residents were receiving bruising from the staff holding and restraining them to provide cares. The administrator stated if the DON thought there was abuse occurring in the facility, she would notify him immediately.<br><br>During interview on 4/17/14, at 1:35 p.m. social worker (SW)-A stated she was not aware of the bruising that was occurring from staff restraining R44, R50, R34, and R53 when providing cares. SW-A stated in the daily morning meeting held with herself, RN case managers, and the DON, residents with "bad behavior" were discussed, but specific bruising or specific behaviors were not talked about. SW-A stated she would just "assume" if a resident had combative behaviors when having cares performed bruising happened because "elderly with thin skin would bruise." SW-A stated she would not suspect "our staff" of any abuse because they all know each other so well. SW-A verified in the past the bruising was not investigated, nor were residents who were combative with cares monitored and assessed to ensure appropriate interventions were in place. SW-A stated, "We definitely have a problem [investigating and assessing residents who are combative with cares] that needs to be better." SW-A stated in the past she had not been involved in investigating or tracking resident | F 223 | | |

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 223 | Continued From page 23<br>bruising or behaviors with cares, but going forward she stated she "needs" to be involved.<br><br>The IJ was that began on 4/15/14, at 4:47 p.m. was removed on 4/17/13, at 4:20 p.m. when the facility completed the following interventions:<br><br>All staff were trained on how to deal with residents who are combative during cares and were instructed it is never acceptable to hold a resident down to provide cares.<br>Individual behavior assessments were completed on R44, R50, R34, and R53 and staff were trained on the specific approaches for those residents.<br>A staff meeting was held to identify any other residents with potential to be abusive with staff during cares.<br>Resident care plans were updated and staff was encouraged to communicate with nursing to continue to assess interventions which are successful.<br>Beginning on 4/16/14, the DON, SW-A, and RN case managers, will review all incident reports and sign off on them to ensure all incidents are being investigated. The Incident/ Accident policy was updated on 4/17/14, to include, "An attempt to identify the root cause of incident will be made which may include history of resident's behavior and the staff's response to those behaviors for potential abuse."<br>Skin audits and care/ work audits will begin on 4/21/14 to ensure cares are being performed as assessed to resident's with behaviors.<br>The administrator will oversee the correction plan to ensure compliance.<br><br>The IJ was removed, but non compliance remained at a lower scope/severity of E level, | F 223 | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 223 | Continued From page 24<br>pattern with no actual harm but potential for harm. | F 223 | | |
| F 225 SS=E | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. | F 225 | F225 Plan of correction 5/16/14<br><br>Resident 44, 50, 34, and 53 were assessed for bruising on 4/16/14 which was not correlated to any documented incidents. No injuries were noted on residents 44 and 53. Bruising, not correlated with an incident was located on resident 50 and 34 which were immediately filed to OHFC after the facility administrator was updated. | |

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 225 | Continued From page 25<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 5 of 5 residents (R44, R50, R34, R53, and R16) who experienced injuries of unknown origin, potential staff abuse, and/ or injury resulting from staff providing cares were thoroughly investigated and reported immediately to the administrator and state agency. In addition, the facility failed to ensure 1 of 1 nursing assistant (NA-D) who was disqualified to provide cares to residents without direct supervision was supervised and monitored while providing care to residents.<br><br>Findings include:<br><br>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:<br>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<br>2.) The injury is suspicious because of the extent of the injury or the location of the injury...or 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, | F 225 | 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 any fracture which is obtained during cares.<br><br>All residents in the facility were 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 higher risk of obtaining injury related to their combative and aggressive behaviors. These 4 other residents were also assessed on 4/16/14 for injuries which were not documented in an incident report. No new or | |

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|---|---|---|---|---|
| F 225 | Continued From page 26<br>department supervisor, DON, and other staff as needed are involved in the investigation. Interviews with resident, family, and staff are solicited to gain the best understanding of the event... All staff need to report suspected maltreatment of a vulnerable adult to the supervising nurse on duty or social services. In addition, the facility administrator must be notified of every report immediately... initial incident report must be given to CEP (common entry point) and OHFC (state agency/ office of health facility complaints) immediately after knowledge of the incident is received where there is reason to believe a resident is or has been maltreated or a resident has sustained a physical injury which is not reasonably explained...The individual is disqualified, the Department of Human Services will notify [facility] and the individual and shall inform the individual of the right to request a review of the disqualification by submitting the request to Department of Human Services. This individual may not have further contact with the residents unless permitted by the commission. [facility] is responsible for cooperating with the department of human services. Therefore, an employee who is disqualified will be terminated...<br><br>R44's quarterly Minimum Data Set (MDS) dated 1/16/14, identified the resident had severe cognitive impairment, required extensive assistance with activities of daily living (ADL), and rejected care 4-6 days of the 7 day look back assessment period.<br><br>R44's care plan last updated on 1/24/14, identified the resident had behaviors of being resistive with cares and can become physically and verbally aggressive, and will strike out during | F 225 | unexplained injuries were noted.<br><br>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 reviewed and updated on 4/16/14 to include a more focused "behavior plan". This plan has resident specific interventions for the direct care staff to use when/if the resident displays aggressive behaviors.<br><br>The nursing assistant who had been disqualified from DHS was suspended without pay on 4/16/14 pending the appeal process and was terminated from employment with the facility on 4/24/14 upon the notification that the appeal had been denied and the employee was disqualified from providing services to persons receiving benefits from DHS. | |

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|---|---|
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|---|---|---|---|---|
| F 225 | Continued From page 27<br>cares. The interventions instruct staff, "when doing cares, check/ change in bed; may work better if one person holds her hands and engages her with explanations/ soothing words/ conversation to distract from the cares."<br><br>During interview on 4/15/14, at 8:50 a.m. licensed practical nurse (LPN)-C stated R44 can be a "difficult" resident to provide cares to related to her combative behavior. LPN-C stated in order to provide cares to R44 it may require up to 3 staff to ensure cares can be completed, 2 staff to change the resident's brief 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 is difficult to redirect the resident once she becomes agitated.<br><br>On 4/14/14, the facility provided R44's injury reports from January 1, 2014, to present. The DON stated injury reports prior to January 1, 2014 were shredded. Review of injury reports for R44 revealed the following incidents lacked evidence of a thorough investigation or reporting to the administrator or state agency (SA):<br><br>-An injury report dated 3/2/14, which had been revised on 4/14/14, identified R44, "had incontinent BM [bowel movement] and was combative with AM [morning] cares. Was hitting out at staff. Staff was holding onto her hands to prevent her from digging into BM and striking out at staff. At lunch bruises were noted. Resident was unaware." A Wound Assessment/ Monitoring form dated 3/2/14, identified R44 had left wrist bruising measuring 3.5 cm x 5.2 cm and right wrist bruising measuring 3.6 cm x 2.8 cm. The assessment indicated the specific interventions being used were, "Try to calm and reapproach | F 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 residents in the facility will have weekly skin audits done for 60 days to assure that all residents are being monitored for unknown injuries. The 8 residents above which were determined to be at risk for injury are being audited twice weekly during cares to monitor the direct care staff and resident interaction while cares are being provided. These audits will continue twice weekly for 30 days from 4/21/14 and then weekly for the following 30 days.<br><br>As of 5/16/14, all nursing staff have been assigned two education sessions called "Abuse Prevention In Persons with Dementia: The Basics" and "Client Behaviors: Assessment and Intervention in the | |

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|---|---|---|---|---|
| F 225 | Continued From page 28<br>resident when combative." The nursing progress note dated 3/3/14, indicated, "Both forearms badly bruised." There was no further investigation regarding which staff was involved, nor were there any interviews attempted with the resident to determine if the resident was abused/mistreated. This injury of unknown origin was not reported to the administrator or state agency.<br><br>-An injury report for R44 dated 3/14/14, which had been revised on 4/14/14, identified, "When NA [nursing assistant] were assisting resident with her A.M. cares they noted resident to have 2 bruises to her left forearm. Author observed bruises to be dark purple in color measuring 6 cm x 3 cm and 3 cm x 3 cm. NOC [night] nurse reported resident was very combative during cares and hitting staff with her hands and arms. Is likely bruising is from residents combativeness." There was no further investigation regarding which staff was involved, nor were there any interviews attempted with the resident to determine if the resident was abused/mistreated. This injury of unknown origin was not reported to the administrator or state agency.<br><br>During interview on 4/15/14, at 9:35 a.m. NA-D stated R44 is combative with staff when they are providing cares to the resident. NA-D stated the resident only required one staff assist with cares, but usually 2 staff are required to help so one staff can hold the residents hands down when cares are being done. NA-D stated she knows staff has caused bruising on resident's wrists/ arms/ and ankles from holding them down when staff were trying to get cares done, but "the residents" are so resistive and staff is just trying | F 225 | Resident with Dementia" from the online education system, "Healthcare Academy". The staff have until June 6th, 2014 to complete the required education courses until discipline is enforced by administration.<br><br>The following system changes have taken place since 4/16/14- 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 an RN. The administrator will be notified immediately of any VA reportable incidents per the Vulnerable Adult Policy and Procedure on all days of the | |

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|---|---|---|---|---|
| F 225 | Continued From page 29<br>to get the resident's cares done as quickly as possible. NA-D stated she felt "horrible" when resident's had developed bruising from holding them down to perform cares, but she stated "they are just so fragile and struggling with us so much when we are holding them." NA-D stated "about a month ago" R44 needed to have her brief changed and was resistive. NA-D stated staff had to hold the residents wrists/ hands so the resident could be cleaned up. NA-D stated about 2-3 hours later staff observed R44's wrists had bruising on "like perfect hand prints."<br><br>R50's admission MDS dated 2/18/14, identified the resident had severe cognitive impairment, required extensive assistance with all ADLs, and rejected care 4-6 days of the 7 look back assessment period.<br><br>R50's care plan, updated 4/14/14, identified the resident was resistive with cares, wanders, verbal and physical resistance with cares, and may reach out and grab at other people in her path. The interventions included allow time for thought process when providing cares, keep her warm during cares, and attempt to distract with music or items to manipulate her hands.<br><br>On 4/14/14, the facility was asked to provide R50's injury reports from January 1, 2014, to present. The DON stated R50 had no injury reports/ investigations.<br><br>Review of R50's Wound Assessment/ Monitoring form, dated 4/3/14, identified R50 had left forearm bruising measuring approximately 6 cm in length and 1 cm wide; reddish/ purple in color. There was no assessment or investigation of the bruise. The injury of unknown origin was not | F 225 | week including weekends. On 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 by the DON on 4/16/14 to include the addition of individualized "behavior plans" which will be put into place if a resident is at risk of injury related to aggressive behaviors. On 4/17/14 the DON, Administrator and LSW reviewed the facility Vulnerable Adult Policy and Procedure and made multiple changes which include the addition of reference checks, suspension for employees under investigation by DHS, training of new employees with a focus on Alzheimer's/dementia care, staff burnout, and supportive care of the residents during pending investigation of an incident. On 4/17/14 the DON | |

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

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|---|---|---|---|---|
| F 225 | Continued From page 30<br>reported to the administrator or SA.<br><br>During interview on 4/15/14, at 9:35 a.m. NA-D stated R50 is combative "all the time" with "any cares staff attempts to provide to the resident." NA-D stated staff tries to redirect the resident by talking with her, but R50 can not be redirected. NA-D stated sometimes it takes 3 staff to change the resident's brief because the resident is "pretty big and strong." She stated the resident's bed is against the wall, and one staff stands above R50's head to hold her arms down, and the other two staff get the residents cares done. NA-D stated, "We have to hold her down to get her cares done or they would never get done." NA-D stated she reports the resident's behaviors to the charge nurse "all the time" but nothing is ever done to help caring for R50 any easier. NA-D stated, "I know it isn't right [to hold residents down] but how else do you do cares?"<br><br>R34's quarterly MDS, dated 2/13/14, identified the resident had moderate cognitive impairment, required extensive assistance with ADLs, and rejected care 1-3 days of the 7 day look back assessment period.<br><br>R34's care plan, dated 2/27/14, identified the resident is verbally aggressive and resistive to cares. The interventions to be used were reapproach with different staff if refusing cares, report to nurse cause and effect relationship when behavior is exhibited, assure good communication is maintained and resident understands what is happening, set limits for behavior with resident. If non-compliant and safe, leave situation until behavior stops. Reapproach later "verbally demand behavior stop." | F 225 | 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. | |

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|---|---|---|---|
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|---|---|
| COMMUNITY MEMORIAL HOME | 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 225 | Continued From page 31<br>During interview on 4/15/14, at 8:50 a.m. LPN-C stated R34 is combative with cares. LPN-C stated staff will sometimes try to reapproach the resident later to provide cares, but, if that doesn't work they will need to have extra staff to assist with holding the resident's arms and legs to provide the cares. LPN-C stated often holding R34's arms and legs down is the only way to get cares done on R34.<br><br>On 4/14/14, the facility provided R34's injury reports from January 1, 2014, to present. The DON stated injury reports prior to January 1, 2014, were shredded.<br><br>One injury report was provided for R34 which was dated 1/20/14. The report indicated, "Noted to have bruising to bilateral arms and wrists, has had increased physical behaviors with staff during cares, including hitting at staff and hitting PAL lift with fists, bare hands typically during cares and transfers." The immediate action taken was, "Monitor bruising until healed. Leave and re approach when angry with cares." There was no further investigation or evidence of reporting to the administrator or SA the injury of unknown origin.<br><br>Review of R34's Wound Assessment Monitoring identified the following injuries of unknown origin that lacked evidence of a thorough investigation or reporting to administrator and SA:<br>-12/28/13- Right forearm bruising 3.5 cm x 2.3 cm. Right forearm bruising 9.5 cm x 5 cm x 0.2 cm [depth]. The monitoring form identified the bruising was dark purple.<br>-1/6/14- Multiple bruising to left arm. Bruising to left hand [back] measuring 4 cm x 6 cm. The appearance indicated, "Bruising to hand and | F 225 | Risk meetings will be held monthly starting in May 2014, and will have a focus on reviewing incidents/accidents and individual resident care plans to address behavior plans and interventions. This meeting will continue indefinitely and the trends developed by this team will be brought forth and discussed during the facility's QA&A meetings. The administrator will audit to make sure that the incident reports and risk meeting notes are brought to the QA meetings for review by the team.<br><br>The corrective action for F225 was completed on 5/16/14 | |

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 225 | Continued From page 32<br>multiple to left arm. Bruises are dark blue/ purple in color. Discontinue mobility bars in bed. Resident may be bumping her arms on these."<br>-1/11/14- Right forearm bruising. "Dark purple around the edges of bruising. Appears to be fading in the middle. Yellow color to middle of bruise."<br>-1/20/14- Left back hand bruising and left arm bruising. "Has one penny sized bruise present on the left hand and has multiple bruises present on her forearm."<br><br>During interview on 4/15/14, at 9:05 a.m. NA-A stated R34 is often combative with cares. NA-A stated it will often take "a few of us" to provide cares because one has to hold her hands while the other staff is providing the cares. NA-A stated R34 is very combative when males provide cares because she doesn't like men to take care of her.<br><br>R53's annual MDS dated 1/9/14, identified the resident had moderate cognitive impairment, required extensive assistance with ADLs, and rejected care 1-3 days of the 7 day look back assessment period.<br><br>R53's plan of care dated 4/14/14, identified the resident hollers and yells if "painful, [did not identify what painful meant] wants attention, or for no reason...not always redirectable..." The interventions include ask the resident why he is yelling, is a 1 assist of staff, but if not cooperative use 2 staff.<br><br>During interview on 4/15/14, at 9:05 a.m. NA-A stated R53 is often combative with cares. NA-A stated she does not work with R53 often, but when she has she had to have extra staff available to hold the resident's arms down to | F 225 | | |

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|---|---|
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|---|---|---|---|---|
| F 225 | Continued From page 33<br>provide cares due to the resident being combative.<br><br>On 4/14/14 the facility provided R53's injury reports from January 1, 2014, to present. The DON stated injury reports prior to January 1, 2014, were shredded.<br><br>The facility provided one injury report for R53 dated 3/2/14, with a revision date of 4/14/14, which identified the resident was "combative with HS [bedtime] cares, to thrashing arms in PAL. Abrasion noted to left arm after HS cares completed... Checked PAL and bed for sharp edges." A Wound Assessment and Monitoring Report identified R53 had (2) left antecubital abrasion(s) measuring 1.3 cm x 0.7 cm and 1 cm x 0.3 cm. The interventions listed were, "Check for any sharp edges." There was no further investigation regarding which staff was involved, nor were there any interviews attempted with the resident to determine if the resident was abused/mistreated. This injury of unknown origin was not reported to the administrator or state agency.<br><br>During interview on 4/15/13, at 9:35 a.m. NA-D stated R53 was combative with cares and "just about anytime you try to do something with him." NA-D stated two staff can usually "handle him," but if he is combative staff tries to walk away and reapproach him later. NA-D stated if staff comes back and R53 is still combative, staff will need to restrain him [hold his hands/ legs] to do cares. NA-D stated, "We do what we have to do to complete cares."<br><br>R16's quarterly MDS dated 3/6/14, identified the resident had moderate cognitive impairment and | F 225 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 225 | Continued From page 34<br>required extensive assistance with all ADL.<br><br>R16's care plan dated 3/18/14, identified the resident was resistive with cares and instructed staff to report to nurse cause and effect relationships when behavior was exhibited.<br><br>A facility injury report dated 3/11/14, identified on 3/11/14, NA-D and NA-A were providing peri care to the resident and they said they heard a "pop" noise while doing cares. The summary of the incident contained the following:<br>- ..."had cleaned incontinent bowels off her backside and were attempting to clean her front as there was a significant amount of stool that had traveled up into pubic region. As one staff started to gently spread legs slightly apart at the knees to allow her partner to access to clean peri area she felt a 'pop....' [R16] hollered out in pain and the nurse was immediately summoned to the room... Resident was transferred to hospital via ambulance... placed call to [hospital] and gave staff an update on incident and fracture of left femur."<br><br>During interview on 4/15/14, at 12:11 p.m. DON stated she did not report R16's fracture to the state agency because the staff had the same story of what happened and they both felt "horrible." The DON verified she had not been tracking which staff were involved in resident injuries /bruising/ incidents to ensure there was no staff pattern. DON verified NA-D was disqualified from working with resident's by the Department of Human Services and was not to be providing resident cares on 3/11/14, without direct supervision.<br><br>During interview on 4/15/14, at 8:50 a.m. LPN-C | F 225 | | |

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 225 | Continued From page 35<br>stated if a resident was observed with bruising she would ensure the bruising was monitored to ensure healing. LPN-C stated she was aware staff needed to hold combative resident's down to provide cares and was aware bruising had resulted from staff restraining resident's. LPN-C stated she did not think the bruising required investigation or reporting because she was aware the bruising was related to the resident being combative. LPN-C stated an injury/ incident report is not always filled out for bruising, especially if it is known where the bruising came from.<br><br>During interview on 4/15/14, at 12:10 p.m. DON stated she was aware staff needed to restrain combative residents to do cares. The DON stated if a resident is combative or resistive with cares staff should leave the resident safe, and reapproach. DON stated, "The cares have to get done for these residents" and there are just some residents "who are difficult." She stated when a resident has dementia, there is a risk the resident may be resistive with cares and staff needs to get "cares done as quickly as possible for these residents, you cant just leave them in a soiled brief and not get cares done." DON stated, "There is a point we have to provide cares and I know that resident's are held down." DON stated staff was restraining residents for their own safety to make sure the resident's were not striking staff or injuring themselves. DON verified injury report's of bruising was documented at times related to "combative with cares." She stated this bruising was not suspicious and did not require a full investigation or reporting to the administrator or state agency, because the facility was aware where the bruising came from and knew the resident's "weren't being abused." DON stated | F 225 | | |

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|---|---|---|---|
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|---|---|---|---|---|
| F 225 | Continued From page 36<br>she never considered the residents were being abused as she felt the staff were doing their best to care for the difficult residents.<br><br>During interview on 4/16/14, at 1:30 p.m., facility administrator stated he was not aware residents were receiving bruising from the staff holding and restraining them to provide cares. The administrator stated if the DON thought their was abuse occurring in the facility, she would notify him immediately.<br>Background Study<br>The employee file of NA-D was reviewed. A letter was found in the file, dated 2/27/14, referencing the background study for NA-D. The letter informed the facility the employee had been disqualified from any position that allowed direct contact with or access to persons who received services from state regulatory agencies. The letter also informed the facility that it may choose to allow the person to provide direct contact services pending a possible reconsideration decision by the Commissioner and if they chose this option they must do the following:<br>· Obtain from the employee a copy of the notice of disqualification which explained the reason for the disqualification;<br>· Ensure the employee requested reconsideration within 30 days of receiving the notice of disqualification and;<br>· Ensure the employee was under continuous, direct supervision when providing direct contact services with persons receiving services from your program, pending reconsideration of the disqualification.<br><br>An interview with human resources (HR)-A was completed on 4/16/14, at 12:02 p.m. HR-A verified the employee (NA-D) had been employed | F 225 | | |

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

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|---|---|
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|---|---|---|---|---|
| F 225 | Continued From page 37<br>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.<br><br>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).<br>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 | F 225 | | |

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|---|---|
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|---|---|---|---|---|
| F 225 | Continued From page 38 | F 225 | | |

employee did not need direct supervision. 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 had 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 residents, independently and behind closed doors. She acknowledged the licensed nurse on duty was to supervise the employee but acknowledged no special plan had been devised related to any special supervision for NA-D.
An interview with the DON and NA-D was completed on 4/16/14, at 3:05 p.m. During the interview, NA-D reported "had no idea as to why I would be disqualified" and she had contacted Background Division but they would not tell her the rationale over the phone. NA-D adamantly denied she was sent a letter explaining the rationale for the disqualification. NA-D reported she needed to provide FBI fingerprints, letters of recommendations from the DON, her direct supervisor and two of her coworkers in order for the agency to reconsider the disqualification. She reported she obtained these items and mailed them on 3/7/14, and provided a receipt of the letter mailed to the DON, after which she was allowed to return to work. She indicated she returned under supervision of the LPN on duty and used the buddy system with the two other staff that she worked with. NA-D indicated the "buddy system" meant the nursing assistant's cared for a group of resident's they were assigned to and that she did not need "a babysitter." She reported she could and did independently care for residents, with no special limitations. She verified it was acceptable for her to independently provide cares to resident's in

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|---|---|---|---|
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|---|---|---|---|---|
| F 225 | Continued From page 39<br>their rooms with the door closed and she was under no special supervision.<br><br>An interview with the administrator was 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 resident's independently while waiting for a decision related to the reconsideration of the disqualification. When asked as to the definition of "continuous direct supervision," he did not respond. | F 225 | | |
| F 226 SS=F | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 5 of 5 residents (R44, R50, R34, R53, and R16) who experienced injuries of unknown origin, potential staff abuse, and/ or injury resulting from staff providing cares were thoroughly investigated, tracked, and reported immediately to the administrator and state agency per facility policy. The facility Vulnerable Adult Policy and Procedure/ Prevention Plan lacked instruction on protecting the resident during an investigation, how staff will be supervised during an investigation, definition and identifying staff burnout, training on how to | F 226 | F226 Plan of correction 5/16/14<br><br>Resident 44, 50, 34, and 53 were assessed for bruising on 4/16/14 which was not correlated to any documented incidents. No injuries were noted on residents 44 and 53. Bruising, not correlated with an incident was located on resident 50 and 34 which were immediately filed to OHFC after the facility administrator was updated. | |

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 226 | Continued From page 40<br>deal with resident aggression, and obtaining reference checks on employees before beginning employment.<br><br>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.<br><br>Findings include:<br><br>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:<br>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<br>2.) The injury is suspicious because of the extent of the injury or the location of the injury...or 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 resident, family, and staff are | 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 any fracture which is obtained during cares.<br><br>All residents in the facility were 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 higher risk of obtaining injury related to their combative and aggressive behaviors. These 4 other residents were also assessed on 4/16/14 for injuries which were not documented in an incident report. No new or | |

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|---|---|---|---|
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|---|---|---|---|---|
| F 226 | Continued From page 41<br>solicited to gain the best understanding of the event... All staff need to report suspected maltreatment of a vulnerable adult to the supervising nurse on duty or social services. In addition, the facility administrator must be notified of every report immediately... initial incident report must be given to CEP (common entry point) and OHFC (state agency/ office of health facility complaints) immediately after knowledge of the incident is received where there is reason to believe a resident is or has been maltreated or a resident has sustained a physical injury which is not reasonably explained...The individual is disqualified, the Department of Human Services will notify [facility] and the individual and shall inform the individual of the right to request a review of the disqualification by submitting the request to Department of Human Services. This individual may not have further contact with the residents unless permitted by the commission. [facility] is responsible for cooperating with the department of human services. Therefore, an employee who is disqualified will be terminated...<br><br>R44's quarterly Minimum Data Set (MDS) dated 1/16/14, identified the resident had severe cognitive impairment, required extensive assistance with activities of daily living (ADL), and rejected care 4-6 days of the 7 day look back assessment period.<br><br>R44's care plan last updated on 1/24/14, identified the resident had behaviors of being resistive with cares and can become physically and verbally aggressive, and will strike out during cares. The interventions instruct staff, "when doing cares, check/ change in bed; may work better if one person holds her hands and engages | F 226 | unexplained injuries were noted.<br>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 related to aggressive behaviors 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 care staff to use when/if the resident displays aggressive behaviors.<br><br>The nursing assistant who had been disqualified from DHS was suspended without pay on 4/16/14 pending the appeal process and was terminated from employment with the facility on 4/24/14 upon the notification that the appeal had been denied and the employee was disqualified from providing services to persons receiving benefits from DHS. | |

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| F 226 | Continued From page 42<br>her with explanations/ soothing words/ conversation to distract from the cares."<br><br>During interview on 4/15/14, at 8:50 a.m. licensed practical nurse (LPN)-C stated R44 can be a "difficult" resident to provide cares to related to her combative behavior. LPN-C stated in order to provide cares to R44 it may require up to 3 staff to ensure cares can be completed, 2 staff to change the resident's brief 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 is difficult to redirect the resident once she becomes agitated.<br><br>On 4/14/14, the facility provided R44's injury reports from January 1, 2014, to present. The DON stated injury reports prior to January 1, 2014 were shredded. Review of injury reports for R44 revealed the following incidents lacked evidence of a thorough investigation or reporting to the administrator or state agency (SA):<br><br>-An injury report dated 3/2/14, which had been revised on 4/14/14, identified R44, "had incontinent BM [bowel movement] and was combative with AM [morning] cares. Was hitting out at staff. Staff was holding onto her hands to prevent her from digging into BM and striking out at staff. At lunch bruises were noted. Resident was unaware." A Wound Assessment/ Monitoring form dated 3/2/14, identified R44 had left wrist bruising measuring 3.5 cm x 5.2 cm and right wrist bruising measuring 3.6 cm x 2.8 cm. The assessment indicated the specific interventions being used were, "Try to calm and reapproach resident when combative." The nursing progress note dated 3/3/14, indicated, "Both forearms badly bruised." There was no further investigation | 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 residents in the facility will have weekly skin audits done for 60 days to assure that all residents are being monitored for unknown injuries. The 8 residents above which were determined to be at risk for injury are being audited twice weekly during cares to monitor the direct care staff and resident interaction while cares are being provided. These audits will continue twice weekly for 30 days from 4/21/14 and then weekly for the following 30 days.<br><br>As of 5/16/14, all nursing staff have been assigned two education sessions called "Abuse Prevention In Persons with Dementia: The Basics" and "Client Behaviors: Assessment and Intervention in the | |

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| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 226 | Continued From page 43<br>regarding which staff was involved, nor were there any interviews attempted with the resident to determine if the resident was abused/mistreated. This injury of unknown origin was not reported to the administrator or state agency.<br><br>-An injury report for R44 dated 3/14/14, which had been revised on 4/14/14, identified, "When NA [nursing assistant] were assisting resident with her A.M. cares they noted resident to have 2 bruises to her left forearm. Author observed bruises to be dark purple in color measuring 6 cm x 3 cm and 3 cm x 3 cm. NOC [night] nurse reported resident was very combative during cares and hitting staff with her hands and arms. Is likely bruising is from residents combativeness." There was no further investigation regarding which staff was involved, nor were there any interviews attempted with the resident to determine if the resident was abused/mistreated. This injury of unknown origin was not reported to the administrator or state agency.<br><br>During interview on 4/15/14, at 9:35 a.m. NA-D stated R44 is combative with staff when they are providing cares to the resident. NA-D stated the resident only required one staff assist with cares, but usually 2 staff are required to help so one staff can hold the residents hands down when cares are being done. NA-D stated she knows staff has caused bruising on resident's wrists/ arms/ and ankles from holding them down when staff were trying to get cares done, but "the residents" are so resistive and staff is just trying to get the resident's cares done as quickly as possible. NA-D stated she felt "horrible" when resident's had developed bruising from holding | F 226 | Resident with Dementia" from the online education system, "Healthcare Academy". The staff have until June 6th, 2014 to complete the required education courses until discipline is enforced by administration.<br><br>The following system changes have taken place since 4/16/14- 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 an RN. The administrator will be notified immediately of any VA reportable incidents per the Vulnerable Adult Policy and | |

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|---|---|---|---|---|
| F 226 | Continued From page 44<br>them down to perform cares, but she stated "they are just so fragile and struggling with us so much when we are holding them." NA-D stated "about a month ago" R44 needed to have her brief changed and was resistive. NA-D stated staff had to hold the residents wrists/ hands so the resident could be cleaned up. NA-D stated about 2-3 hours later staff observed R44's wrists had bruising on "like perfect hand prints."<br><br>R50's admission MDS dated 2/18/14, identified the resident had severe cognitive impairment, required extensive assistance with all ADLs, and rejected care 4-6 days of the 7 look back assessment period.<br><br>R50's care plan, updated 4/14/14, identified the resident was resistive with cares, wanders, verbal and physical resistance with cares, and may reach out and grab at other people in her path. The interventions included allow time for thought process when providing cares, keep her warm during cares, and attempt to distract with music or items to manipulate her hands.<br><br>On 4/14/14, the facility was asked to provide R50's injury reports from January 1, 2014, to present. The DON stated R50 had no injury reports/ investigations.<br><br>Review of R50's Wound Assessment/ Monitoring form, dated 4/3/14, identified R50 had left forearm bruising measuring approximately 6 cm in length and 1 cm wide; reddish/ purple in color. There was no assessment or investigation of the bruise. The injury of unknown origin was not reported to the administrator or SA.<br><br>During interview on 4/15/14, at 9:35 a.m. NA-D | F 226 | Procedure on all days of the week including weekends. On 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 by the DON on 4/16/14 to include the addition of individualized "behavior plans" which will be put into place if a resident is at risk of injury related to aggressive behaviors. On 4/17/14 the DON, Administrator and LSW reviewed the facility Vulnerable Adult Policy and Procedure and made multiple changes which include the addition of reference checks, suspension for employees under investigation by DHS, training of new employees with a focus on Alzheimer's/dementia care, staff burnout, and supportive care of the residents during | |

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|---|---|---|---|---|
| F 226 | Continued From page 45<br>stated R50 is combative "all the time" with "any cares staff attempts to provide to the resident." NA-D stated staff tries to redirect the resident by talking with her, but R50 can not be redirected. NA-D stated sometimes it takes 3 staff to change the resident's brief because the resident is "pretty big and strong." She stated the resident's bed is against the wall, and one staff stands above R50's head to hold her arms down, and the other two staff get the residents cares done. NA-D stated, "We have to hold her down to get her cares done or they would never get done." NA-D stated she reports the resident's behaviors to the charge nurse "all the time" but nothing is ever done to help caring for R50 any easier. NA-D stated, "I know it isn't right [to hold residents down] but how else do you do cares?"<br><br>R34's quarterly MDS, dated 2/13/14, identified the resident had moderate cognitive impairment, required extensive assistance with ADLs, and rejected care 1-3 days of the 7 day look back assessment period.<br><br>R34's care plan, dated 2/27/14, identified the resident is verbally aggressive and resistive to cares. The interventions to be used were reapproach with different staff if refusing cares, report to nurse cause and effect relationship when behavior is exhibited, assure good communication is maintained and resident understands what is happening, set limits for behavior with resident. If non-compliant and safe, leave situation until behavior stops. Reapproach later "verbally demand behavior stop."<br><br>During interview on 4/15/14, at 8:50 a.m. LPN-C stated R34 is combative with cares. LPN-C stated staff will sometimes try to reapproach the | 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.<br><br>On 5/16/14, a check box was added to new hire paperwork which includes a prompt/reminder that a | |

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| F 226 | Continued From page 46<br>resident later to provide cares, but, if that doesn't work they will need to have extra staff to assist with holding the resident's arms and legs to provide the cares. LPN-C stated often holding R34's arms and legs down is the only way to get cares done on R34.<br><br>On 4/14/14, the facility provided R34's injury reports from January 1, 2014, to present. The DON stated injury reports prior to January 1, 2014, were shredded.<br><br>One injury report was provided for R34 which was dated 1/20/14. The report indicated, "Noted to have bruising to bilateral arms and wrists, has had increased physical behaviors with staff during cares, including hitting at staff and hitting PAL lift with fists, bare hands typically during cares and transfers." The immediate action taken was, "Monitor bruising until healed. Leave and re approach when angry with cares." There was no further investigation or evidence of reporting to the administrator or SA the injury of unknown origin.<br><br>Review of R34's Wound Assessment Monitoring identified the following injuries of unknown origin that lacked evidence of a thorough investigation or reporting to administrator and SA:<br>-12/28/13- Right forearm bruising 3.5 cm x 2.3 cm. Right forearm bruising 9.5 cm x 5 cm x 0.2 cm [depth]. The monitoring form identified the bruising was dark purple.<br>-1/6/14- Multiple bruising to left arm. Bruising to left hand [back] measuring 4 cm x 6 cm. The appearance indicated, "Bruising to hand and multiple to left arm. Bruises are dark blue/ purple in color. Discontinue mobility bars in bed. Resident may be bumping her arms on these." | F 226 | reference check is needed. The business office staff will audit to make sure that a reference has been checked on all new hires.<br><br>Risk meetings will be held monthly starting in May 2014, and will have a focus on reviewing incidents/accidents and individual resident care plans to address behavior plans and interventions. This meeting will continue indefinitely and the trends developed by this team will be brought forth and discussed during the facility's QA&A meetings. The administrator will complete audits to assure that the incident reports and Risk notes have been brought to the QA meeting and reviewed assuring that adequate and appropriate reporting has occurred.<br><br>The corrective action for F226 was completed on 5/16/14 | |

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|---|---|---|---|---|
| F 226 | Continued From page 47<br>-1/11/14- Right forearm bruising. "Dark purple around the edges of bruising. Appears to be fading in the middle. Yellow color to middle of bruise."<br>-1/20/14- Left back hand bruising and left arm bruising. "Has one penny sized bruise present on the left hand and has multiple bruises present on her forearm."<br><br>During interview on 4/15/14, at 9:05 a.m. NA-A stated R34 is often combative with cares. NA-A stated it will often take "a few of us" to provide cares because one has to hold her hands while the other staff is providing the cares. NA-A stated R34 is very combative when males provide cares because she doesn't like men to take care of her.<br><br>R53's annual MDS dated 1/9/14, identified the resident had moderate cognitive impairment, required extensive assistance with ADLs, and rejected care 1-3 days of the 7 day look back assessment period.<br><br>R53's plan of care dated 4/14/14, identified the resident hollers and yells if "painful, [did not identify what painful meant] wants attention, or for no reason...not always redirectable..." The interventions include ask the resident why he is yelling, is a 1 assist of staff, but if not cooperative use 2 staff.<br><br>During interview on 4/15/14, at 9:05 a.m. NA-A stated R53 is often combative with cares. NA-A stated she does not work with R53 often, but when she has she had to have extra staff available to hold the resident's arms down to provide cares due to the resident being combative. | F 226 | | |

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|---|---|---|---|
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|---|---|---|---|---|
| F 226 | Continued From page 48<br>On 4/14/14 the facility provided R53's injury reports from January 1, 2014, to present. The DON stated injury reports prior to January 1, 2014, were shredded.<br><br>The facility provided one injury report for R53 dated 3/2/14, with a revision date of 4/14/14, which identified the resident was "combative with HS [bedtime] cares, to thrashing arms in PAL. Abrasion noted to left arm after HS cares completed... Checked PAL and bed for sharp edges." A Wound Assessment and Monitoring Report identified R53 had (2) left antecubital abrasion(s) measuring 1.3 cm x 0.7 cm and 1 cm x 0.3 cm. The interventions listed were, "Check for any sharp edges." There was no further investigation regarding which staff was involved, nor were there any interviews attempted with the resident to determine if the resident was abused/mistreated. This injury of unknown origin was not reported to the administrator or state agency.<br><br>During interview on 4/15/13, at 9:35 a.m. NA-D stated R53 was combative with cares and "just about anytime you try to do something with him." NA-D stated two staff can usually "handle him," but if he is combative staff tries to walk away and reapproach him later. NA-D stated if staff comes back and R53 is still combative, staff will need to restrain him [hold his hands/ legs] to do cares. NA-D stated, "We do what we have to do to complete cares."<br><br>R16's quarterly MDS dated 3/6/14, identified the resident had moderate cognitive impairment and required extensive assistance with all ADL.<br><br>R16's care plan dated 3/18/14, identified the | F 226 | | |

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

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| F 226 | Continued From page 49<br>resident was resistive with cares and instructed staff to report to nurse cause and effect relationships when behavior was exhibited.<br><br>A facility injury report dated 3/11/14, identified on 3/11/14, NA-D and NA-A were providing peri care to the resident and they said they heard a "pop" noise while doing cares. The summary of the incident contained the following:<br>- ..."had cleaned incontinent bowels off her backside and were attempting to clean her front as there was a significant amount of stool that had traveled up into pubic region. As one staff started to gently spread legs slightly apart at the knees to allow her partner to access to clean peri area she felt a 'pop....' [R16] hollered out in pain and the nurse was immediately summoned to the room... Resident was transferred to hospital via ambulance... placed call to [hospital] and gave staff an update on incident and fracture of left femur."<br><br>During interview on 4/15/14, at 12:11 p.m. DON stated she did not report R16's fracture to the state agency because the staff had the same story of what happened and they both felt "horrible." The DON verified she had not been tracking which staff were involved in resident injuries /bruising/ incidents to ensure there was no staff pattern. DON verified NA-D was disqualified from working with resident's by the Department of Human Services and was not to be providing resident cares on 3/11/14, without direct supervision.<br><br>During interview on 4/15/14, at 8:50 a.m. LPN-C stated if a resident was observed with bruising she would ensure the bruising was monitored to ensure healing. LPN-C stated she was aware | F 226 | | |

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|---|---|---|---|
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|---|---|
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|---|---|---|---|---|
| F 226 | Continued From page 50<br>staff needed to hold combative resident's down to provide cares and was aware bruising had resulted from staff restraining resident's. LPN-C stated she did not think the bruising required investigation or reporting because she was aware the bruising was related to the resident being combative. LPN-C stated an injury/ incident report is not always filled out for bruising, especially if it is known where the bruising came from.<br><br>During interview on 4/15/14, at 12:10 p.m. DON stated she was aware staff needed to restrain combative residents to do cares. The DON stated if a resident is combative or resistive with cares staff should leave the resident safe, and reapproach. DON stated, "The cares have to get done for these residents" and there are just some residents "who are difficult." She stated when a resident has dementia, there is a risk the resident may be resistive with cares and staff needs to get "cares done as quickly as possible for these residents, you cant just leave them in a soiled brief and not get cares done." DON stated, "There is a point we have to provide cares and I know that resident's are held down." DON stated staff was restraining residents for their own safety to make sure the resident's were not striking staff or injuring themselves. DON verified injury report's of bruising was documented at times related to "combative with cares." She stated this bruising was not suspicious and did not require a full investigation or reporting to the administrator or state agency, because the facility was aware where the bruising came from and knew the resident's "weren't being abused." DON stated she never considered the residents were being abused as she felt the staff were doing their best to care for the difficult residents. | F 226 | | |

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|---|---|---|---|
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|---|---|
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| F 226 | Continued From page 51<br><br>During interview on 4/16/14, at 1:30 p.m., facility administrator stated he was not aware residents were receiving bruising from the staff holding and restraining them to provide cares. The administrator stated if the DON thought their was abuse occurring in the facility, she would notify him immediately.<br><br>REFERENCE CHECKS<br><br>The employee file of NA-I was reviewed. NA-I had worked at the facility since 6/17/13, and provided direct resident care. No documentation was found in the personnel file of personal/professional references being contacted.<br><br>The employee file of NA-J was reviewed. NA-J had worked at the facility since 8/26/13, and provided direct resident care. No documentation was found in the personnel file of personal/professional references being contacted<br><br>The employee file of NA-D was reviewed. NA-D had worked at the facility since 9/5/13, and provided direct resident care. No documentation was found in the personnel file of personal/professional references being contacted The employee file of NA-E was reviewed. NA-E had worked at the facility since 9/9/13, and provided direct resident care. No documentation was found in the personnel file of personal/professional references being contacted The employee file of NA-C was reviewed. NA-C had worked at the facility since 9/12/13, and provided direct resident care. No documentation was found in the personnel file of | F 226 | | |

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|---|---|---|---|
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| F 226 | Continued From page 52<br>personal/professional references being contacted<br><br>The employee file of NA-K was reviewed. NA-K had worked at the facility since 9/20/13, and provided direct resident care. No documentation was found in the personnel file of personal/professional references being contacted<br><br>The employee file of NA-L was reviewed. NA-L had worked at the facility since 12/10/13, and provided direct resident care. No documentation was found in the personnel file of personal/professional references being contacted.<br><br>An interview with the DON was completed on 4/17/14, at 9:20 a.m. She reported she was responsible to check potential employee's references and should have done this for any employee they were considering hiring. She was unable to provide evidence that these employees' reference's had been checked.<br><br>Background Study<br>The employee file of NA-D was reviewed. A letter was found in the file, dated 2/27/14, referencing the background study for NA-D. The letter informed the facility the employee had been disqualified from any position that allowed direct contact with or access to persons who received services from state regulatory agencies. The letter also informed the facility it may choose to allow the person to provide direct contact services pending a possible reconsideration decision by the Commissioner and if they chose this option they must do each of the following:<br><br>· Obtain from the employee a copy of the notice of disqualification which explained the | F 226 | | |

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|---|---|---|---|
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|---|---|---|---|---|
| F 226 | Continued From page 53<br>reason for the disqualification.<br>· Ensure the employee requested reconsideration within 30 days of receiving the notice of disqualification.<br>· Ensure the employee was under continuous, direct supervision when providing direct contact services with persons receiving services from the facility, pending reconsideration of the disqualification.<br><br>An interview with human resources (HR)-A was completed on 4/16/14, at 12:02 p.m. HR-A did verify the employee (NA-D) had been employed since 9/5/13 and the initial Background Study result's were received by the facility on 9/11/13, which did not indicate any problem with the employee providing cares for residents. HR-A verified he had received the disqualification letter around 2/27/14 and 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.<br><br>An interview with the DON was completed on 4/16/14, at 2:14 p.m. 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 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 | F 226 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 226 | Continued From page 54 | F 226 | | |

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 employee did not need "direct supervision". 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 had 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 resident's independently and behind closed doors. She acknowledged the licensed nurse on duty was to supervise the employee but acknowledged no special plan had been devised related to any special supervision for NA-D. The DON verified she did not feel she needed to know about the reason for disqualification as this was a employee "privacy issue" which was outside of the facility.

An interview with the DON and NA-D was completed on 4/16/14 at 3:05 p.m. During the interview, NA-D reported "had no idea as to why I would be disqualified" and she had contacted the Background Division but they would not tell her the rationale over the phone. NA-D adamantly denied she was sent a letter explaining the rationale for the disqualification, but the letter only identified she was disqualified. NA-D reported

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 226 | Continued From page 55<br>she needed to provide FBI fingerprints, letters of recommendations from the DON, her direct supervisor, and two of her coworkers in order for the agency to reconsider the disqualification. She reported she obtained these items and mailed them on 3/7/14 and provided a receipt of the letter mailed to the DON, after which time she was allowed to return to work. She indicated she returned under supervision of the LPN on duty and used the buddy system with the two other staff she worked with. NA-D indicated the "buddy system" meant the nursing assistant's cared for a group of residents they were assigned to and she did not need "a babysitter." She reported she could and did independently care for resident's, with no special limitations. She verified it was acceptable for her to independently provide cares to residents in their rooms with the door closed and she was under no special supervision.<br><br>An interview with the administrator was completed on 4/16/14 at 3:15 p.m. He acknowledged he was aware of the disqualification letter related to NA-D. He stated he was aware NA-D had returned to the facility and was working with resident's independently while waiting for a decision related to the reconsideration of the disqualification. When asked as to the definition of "continuous direct supervision," he did not respond. | F 226 | | |
| F 250 SS=E | 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE<br><br>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. | F 250 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 250 | Continued From page 56<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to ensure 4 of 4 residents who were combative with staff during cares which resulted in injuries/bruising (R44, R50, R34, and R53) were provided social services to ensure individualized interventions were in place and implemented to ensure combative residents did not receive injury or abuse/mistreatment while receiving cares from staff.<br><br>Findings include:<br><br>R44's 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.<br>During interview on 4/15/14, at 8:50 a.m. licensed practical nurse (LPN)-C stated R44 can be a "difficult" resident to provide cares to related to her combative behavior. LPN-C stated in order to provide cares to R44 it may require up to 3 staff, 2 staff to change the resident's brief and one staff to hold R44's hands down. LPN-C stated it is just easier on R44 to "get the cares done" because it is difficult to redirect the resident once she becomes agitated.<br>R44's care plan last updated on 1/24/14, identified the resident had behaviors of being resistive with cares and can become physically and verbally aggressive, and will strike out during cares. The interventions instructed staff, "when doing cares, check/ change in bed; may work better if one person hold's her hands and | F 250 | F250 Plan of correction on 5/16/14<br><br>Resident 44, 50, 34, and 53 were assessed for bruising on 4/16/14 which was not correlated to any documented incidents. No injuries were noted on residents 44 and 53. Bruising, not correlated with an incident was located on resident 50 and 34 which were immediately filed to OHFC after the facility administrator was updated.<br><br>All residents in the facility were 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 higher risk of obtaining injury related to their combative and aggressive behaviors. These 4 other residents were also assessed on 4/16/14 for injuries which were not documented in an incident report. No new or unexplained injuries were noted. | |

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| F 250 | Continued From page 57<br>engage's her with explanation's/ soothing words/ conversation to distract from the cares."<br>An injury report dated 3/2/14, which had been revised on 4/14/14, identified R44, "had incontinent BM [bowel movement] and was combative with AM [morning] care's. Was hitting out at staff. Staff was holding onto her hand's to prevent her from digging into BM and striking out at staff. At lunch bruises were noted. Resident was unaware." A Wound Assessment/ Monitoring form dated 3/2/14, identified R44 had left wrist bruising measuring 3.5 cm x 5.2 cm and right wrist bruising measuring 3.6 cm x 2.8 cm. The assessment indicated the specific intervention's being used were, "Try to calm and reapproach resident when combative." There was no indication the social worker had reviewed R44's bruising related to being combative with care's.<br>An injury report for R44 dated 3/14/14, which had been revised on 4/14/14, identified, "When NA [nursing assistant] were assisting resident with her A.M. cares they noted resident to have 2 bruises to her left forearm. Author observed bruises to be dark purple in color measuring 6 cm x 3 cm and 3 cm x 3 cm. NOC [night] nurse reported resident was very combative during cares and hitting staff with her hands and arms. Is likely bruising is from resident's combativeness." There was no indication the social worker had reviewed R44's bruising related to being combative with cares.<br>During interview on 4/15/14, at 9:35 a.m. NA-D stated R44 is combative with staff when they are providing cares to the resident. NA-D stated the resident only required one staff assist with cares, but usually 2 staff are required to help so one staff can hold the resident's hands down when cares are being done. NA-D stated she knows staff has caused bruising on resident's wrists/ | F 250 | 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 reviewed and updated on 4/16/14 to include a more focused "behavior plan". This plan has resident specific interventions for the direct care staff to use when/if the resident displays aggressive behaviors. The facility social worker has reviewed and offered input into additional interventions for the behavior plans.<br><br>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 residents in the facility will have weekly skin audits done for 60 days to assure that all residents are being monitored for unknown injuries. The 8 residents above which were determined to be at risk for injury are being | |

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 250 | Continued From page 58<br>arms/ and ankles from holding them down when staff were trying to get cares done, but, "The residents are so resistive and staff is just trying to get the resident's cares done as quickly as possible." NA-D stated she felt "horrible" when resident's had developed bruising from holding them down to perform cares, but she stated, "They are just so fragile and struggling with us so much when we are holding them." NA-D stated "about a month ago" R44 needed to have her brief changed and was resistive. NA-D stated staff had to hold the resident's wrists/ hands so the resident could be cleaned up. NA-D stated about 2-3 hours later "staff" observed R44's wrists had bruising on "like perfect hand prints." NA-D stated that made her feel "horrible."<br>Review of R44's progress notes from 10/3/14 to 4/14/14, identified the resident was identified as being "combative" with cares 18 different occasions. There was no follow up or assessment done by the social worker to ensure interventions were appropriate, being implemented, or to ensure the resident was not receiving injury from staff as a result from being combative.<br>During interview on 4/17/14, at 1:35 p.m. social worker (SW)-A stated she was not aware of the bruising occurring from staff restraining R44 and was not aware of the frequency of R44's combativeness with staff during cares.<br>R50's admission MDS dated 2/18/14, identified the resident had severe cognitive impairment, required extensive assistance with all ADLs, and rejected care 4-6 days of the 7 look back assessment period.<br>During interview on 4/15/14, at 9:05 a.m. NA-A stated R50 is combative "all the time" when staff is attempting to provide cares to the resident. She stated when providing cares to R50 it | F 250 | audited twice weekly during cares to monitor the direct care staff and resident interaction while cares are being provided. These audits will continue twice weekly for 30 days from 4/21/14 and then weekly for the following 30 days. Any new unexplainable injuries will be reported immediately to the administrator and a Vulnerable Adult will be filed to OHFC.<br><br>The following system changes have taken place since 4/16/14-<br>A new facility investigative form was developed and implemented by the DON which includes a review of the incident, interview of staff involved, and care plan interventions. All members of the IDT will review and sign off on the incident including the licensed social worker and administrator Monday through Friday and daily by an RN. On 4/16/14, The Resident Incident/Accident Policy and | |

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 250 | Continued From page 59<br>requires 2 staff, one to provide the cares, and one to hold the resident's hands and feet so cares can be provided. NA-A stated she reports R50's behavior to the nurse "everyday," but does not know what the nurse does with the information as the resident's behavior never improves. NA-A verified she had not been talked to by the social worker regarding R50's behaviors.<br>R50's care plan updated 4/14/14, identified the resident was resistive with cares, wanders, verbal and physical resistance with cares, and may reach out and grab at other's who propel in her path. The interventions included allow time for thought process when providing cares, keep her warm during cares, and attempt to distract with music or items to manipulate her hand's.<br>On 4/14/14, the facility was asked to provide R50's injury reports from January 1, 2014 to present. The DON stated R50 had no injury reports/ investigation's.<br>Review of R50 Wound assessment/ monitoring form dated 4/3/14 identified R50 had left forearm bruising measuring approximately 6 cm in length and 1 cm wide; reddish/ purple in color. There was no assessment or investigation of the bruise nor was it identified the social worker had reviewed the bruise.<br>During interview on 4/15/14, at 9:35 a.m. NA-D stated R50 is combative "all the time with any cares" staff attempt's to provide cares to the resident. NA-D stated staff tries to redirect the resident by talking with her, but R50 can not be redirected. NA-D stated sometime's it takes 3 staff to change the residents brief because the resident is "Pretty big and strong." She stated the resident's bed is against the wall, and one staff stand's above R50's head to hold her arm's down, and the other two staff get the resident's cares done. NA-D stated, "We have to hold her | F 250 | Procedure was updated to include these revisions. The Mood/Behavior Policy and Procedure was also updated by the DON on 4/16/14 to include the addition of individualized "behavior plans" which will be put into place if a resident is at risk of injury related to aggressive behaviors. The facility social worker will be involved in the review and development of the interventions put into place in these care plans during daily IDT meetings, will review with residents and families during care conferences and also during monthly Risk meetings. The social worker was unaware that a quarterly mood and behavior assessment was completed by nursing staff. These assessments review the history of residents' behaviors and current care plan interventions. Moving forward, the social worker will review and be able to add input and will sign off on all mood/behavior | |

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 250 | Continued From page 60<br>down to get her care's done or they would never get done." NA-D stated she reports this to the charge nurse "all the time" but nothing is ever done to help caring for R50 any easier. NA-D stated, "I know it isn't right [to hold residents down], but how else do you do cares?"<br>Review of R50's progress notes from 2/12/14 to 4/13/14, identified the resident as being "combative" with cares on 26 different occasions. There was no further follow up, assessment, or review done by the social worker to ensure interventions were appropriate, being implement, or to ensure the resident was not receiving injury from staff as a result from being combative during cares.<br>During interview on 4/17/14, at 1:35 p.m. SW-A stated she was not aware of the bruising occurring from staff restraining R50 and was not aware of the frequency of R50's combativeness with staff during cares.<br><br>R34's quarterly MDS dated 2/13/14, identified the resident had moderate cognitive impairment, required extensive assistance with ADLs, and rejected care 1-3 days of the 7 day look back assessment period.<br>During interview on 4/15/14, at 8:50 a.m. LPN- C stated R34 is combative with cares. LPN-C stated staff will sometimes try to reapproach the resident later to provide care's, but, if that doesn't work they will need to have extra staff to assist with holding the resident's arms and legs to provide the cares. LPN-C stated often holding R34's arms and legs down is the only way to get cares done on R34.<br>R34's care plan dated 2/27/14, identified the resident is verbally aggressive and resistive to cares. The intervention's to be used were reapproach with different staff if refusing cares, | F 250 | assessments. The social worker will also bring the results of the mood/behavior assessment with to the quarterly care conference 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 on the MDS. Any discrepancies she notes, or if any changes need to be made to the residents' plan of care will be reviewed with the IDT team and passed down to the direct care staff. The social worker completes a social history upon admission. Any information that could be used to assist with decreasing potential behaviors will be added to that residents care plan. On 4/17/14 the DON, Administrator and LSW reviewed the facility Vulnerable Adult Policy and Procedure and made multiple changes which include the addition of reference checks, suspension for employees under investigation by DHS, training of | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 250 | Continued From page 61<br>report to nurse cause and effect relationship when behavior is exhibited, assure good communication is maintained and resident understand's what is happening, set limits for behavior with resident. If non-compliant and safe, leave situation until behavior stops. Reapproach later; "Verbally demand behavior stop."<br>On 4/14/14, the facility provided R34 injury reports from January 1, 2014 to present. The DON stated injury reports prior to January 1, 2014, were shredded.<br>One injury report was provided for R34 which was dated 1/20/14. The report indicated, "Noted to have bruising to bilateral arms and wrists, has had increased physical behaviors with staff during cares, including hitting at staff and hitting PAL lift with fists, bare hands typically during cares and transfers." The immediate action taken was, "Monitor bruising until healed. Leave and re approach when angry with cares." There was no further investigation of this incident nor did the social worker review this bruising related to cares being provided.<br>Review of R34's wound monitoring form identified the following:<br>12/28/13- Right forearm bruising 3.5 cm x 2.3 cm. Right forearm bruising 9.5 cm x 5 cm x 0.2 cm [depth]. The monitoring form identified the bruising was dark purple. There was no indication the social worker had reviewed R34's bruising related to being combative with cares.<br>1/6/14- Multiple bruising to left arm. Bruising to left hand [back] measuring 4 cm x 6 cm. The appearance indicated, "Bruising to hand and multiple to left arm. Bruises are dark blue/ purple in color. Discontinue mobility bars in bed. Resident may be bumping her arms on these."<br>1/11/14- Right forearm bruising. "Dark purple around the edges of bruising. Appears to be | F 250 | new employees with a focus on Alzheimer's/dementia care, staff burnout, and supportive care of the residents during pending investigation of an incident. 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. If abuse has been suspected, a Vulnerable Adult report will be submitted immediately.<br><br>Risk meetings will be held monthly starting in May 2014, and will have a focus on reviewing incidents/accidents and individual resident care plans to address behavior plans and interventions. The social worker will be present and offer input at these meetings. This meeting will continue indefinitely and the trends developed by this team will be brought forth and discussed during the facility's | |

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 250 | Continued From page 62<br>fading in the middle. Yellow color to middle of bruise." There is no further investigation or explanation of the bruising.<br>1/20/14- Left back hand bruising and left arm bruising. "Has one penny sized bruise present on the left hand and has multiple bruises present on her forearm." There is no further investigation or explanation of the bruising.<br>During interview on 4/15/14, at 9:05 a.m. NA-A stated R34 is often combative with cares. NA-A stated it will often take "a few of us" to provide cares because one has to hold her hands while the other staff is providing the cares." NA-A stated R34 is very combative when males provide cares because she doesn't like men to take care of her.<br>Review of R34's progress notes from 12/25/13 to 4/13/14, identified the resident as identified as being "combative" with cares on 13 different occasions. There was no further follow up, assessment, or investigation done by the social worker to ensure interventions were appropriate, being implement, or to ensure the resident was not receiving injury from staff as a result from being combative during cares.<br>During interview on 4/17/14, at 1:35 p.m. SW-A stated she was not aware of the bruising occurring from staff restraining R34, and she was not aware of the frequency of R34's combativeness with staff during cares.<br>R53's annual MDS dated 1/9/14, identified the resident had moderate cognitive impairment, required extensive assistance with ADL, and rejected care 1-3 days of the 7 day look back assessment period.<br>During interview on 4/15/14, at 9:05 a.m. NA-A stated R53 is often combative with cares. NA-A stated she does not work with R53 often, but when she has, she had to have extra staff | F 250 | QA&A meetings which the facility social worker also attends.<br><br>The corrective action for F250 was completed on 5/16/14 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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|---|---|---|---|---|
| F 250 | Continued From page 63 | F 250 | | |

available to hold the resident's arms down to provide cares.
R53's plan of care dated 4/14/14, identified the resident hollers and yells if "painful, want's attention, or for no reason...not always redirectable..." The intervention's include ask the resident why he is yelling, is a 1 assist of staff, but if not cooperative use 2 staff.
On 4/14/14, the facility provided R53's injury reports from January 1, 2014, to present. The DON stated injury reports prior to January 1, 2014, were shredded.
The facility provided one injury report for R53 dated 3/2/14, with a revision date of 4/14/14, which identified the resident was "Combative with HS cares, to thrashing arms in PAL. Abrasion noted to left arm after HS cares completed... Checked PAL and bed for sharp edges." A Wound Assessment and Monitoring Report identified R53 had (2) left antecubital abrasion(s) measuring 1.3 cm x 0.7 cm and 1 cm x 0.3 cm. The interventions listed were, "Check for any sharp edges."
During interview on 4/15/13, at 9:35 a.m. NA-D stated R53 was combative with cares and "just about anytime you try to do something with him." NA-D stated two staff can usually "Handle him," but if he is combative staff tries to walk away and reapproach him later. NA-D stated if staff comes back and R53 is still combative, staff will need to restrain him [hold his hands/ legs] to do care's. NA-D stated, "We do what we have to do" to complete cares.
Review of R53's progress notes from 12/1/13 to 4/13/14, identified the resident as being "Combative" with cares 5 different occasions. There was no further follow up, assessment, or investigation done by the social worker to ensure interventions were appropriate, being implement,

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|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 250 | Continued From page 64<br>or to ensure the resident was not receiving injury from staff as a result from being combative during cares.<br>During interview on 4/15/14, at 8:50 a.m. LPN-C stated if a resident was noted with bruising she would ensure the bruising was monitored to ensure healing. LPN-C stated she was aware staff needed to hold combative resident's down to provide cares and was aware bruising had resulted from staff restraining resident's. LPN-C stated she did not think the bruising required investigation or reporting because she was aware the bruising was related to the resident(s) being combative.<br>During interview on 4/15/14, at 12:10 p.m. DON stated she was aware staff needed to restrain combative residents to do cares. The DON stated if a resident is combative or resistive with cares, staff should leave the resident safe, and reapproach. DON stated, "The cares have to get done for these residents and there are just some residents who are difficult." She stated when a resident has dementia there is a risk the resident may be resistive with cares and staff needs to get "care's done as quickly as possible for these residents you can't just leave them in a soiled brief and not get cares done." DON stated, "There is a point we have to provide cares and I know that residents are held down." DON stated staff was restraining residents for their own safety to make sure the residents were not striking staff or injuring themselves. DON verified injury reports of bruising were documented at times related to "combative with cares." She stated this bruising was not suspicious and did not require a full investigation because the facility was aware where the bruising came from and knew the residents weren't being abused. The DON verified the facility did not complete assessments | F 250 | | |

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|---|---|---|---|---|
| F 250 | Continued From page 65<br>on residents with behaviors or combative with cares to ensure individualized interventions were in place. The DON verified the social worker was not involved in investigations unless they needed to be reported to the state agency.<br>During interview on 4/17/14, at 1:35 p.m. SW-A stated she was not aware of the bruising occurring from staff restraining R44, R50, R34,and R53 when providing cares. SW-A stated in the daily morning meeting held with herself, RN case managers, and the DON, residents with "bad behavior" were discussed, but specific bruising or specific behavior's were not talked about. SW-A stated she would just "assume" if a resident had combative behavior's when having cares performed bruising happened because "Elderly with thin skin would bruise." SW-A stated she would not suspect "Our staff" of any abuse because they all know each other so well. SW-A verified the bruising was not investigated, nor were residents who were combative with cares monitored and assessed to ensure appropriate interventions were in place. SW-A stated, "We definitely have a problem [investigating and assessing residents who are combative with cares] that needs to be better." SW-A stated she had not been involved in any investigating or tracking resident bruising related to combativeness with cares, but going forward she stated she needs to be involved.<br>The facility was asked but did not provide a policy/ procedure on the facility social worker involvement in assessing and investigating resident's who are combative with care. | F 250 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged | F 280 | | |

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

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|---|---|---|---|---|
| F 280 | Continued From page 66<br>incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to review and revise the plan of care for 1 of 4 residents (R29) who experienced repeated injuries from the standing lift.<br><br>Findings include:<br><br>R29's current diagnoses, according to the quarterly Minimum Data Set (MDS) dated 2/06/14, included psychotic disorder, dementia and anxiety. The MDS also revealed significant cognitive impairment, with both long and short-term memory problems.<br><br>Review of R29's wound assessment reports | F 280 | F280 Plan of correction 6/3/14<br><br>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 reviewed and updated on 4/24/14. Care plan was changed from prn to state that resident is to wear the elbow protectors at all times during the day. Dermasaver arm sleeves were ordered and placed on resident on 5/16/14 to decrease incidents of bruising. Care plan was also updated to include these changes. IDT suggested use of Dermasaver shin protectors as well related history of lower extremity bruising and injury. These were ordered on 5/16/14 and will be initiated once arrival to facility.<br><br>Care audits have been in place on behavioral residents since 4/21/14. These audits included watching cares and transfers with the mechanical lifs. Upon review on 6/3/14, it was determined that licensed staff will also conduct transfer audits on all residents currently in house using a mechanical lifting device by 6/6/14. Any safety issues noted during the transfer will result in an immediate review by the RN and input will be requested from Occupational therapy. Transfer audits will continue weekly starting week of 6/9/14 and will continue for 60 days. The audits will consist of auditing the transfer of 10 residents a week to assure that all interventions associated with the | |

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|---|---|---|---|---|
| F 280 | Continued From page 67<br>revealed 19 assessments completed for abrasion injuries to the forehead, arms and shins. The wound assessment reports did not indicate whether the open areas were new sites or continued measurements of a prior injury. The wound assessment reports did not identify the cause of the abrasions.<br><br>R29's care plan, dated 6/19/12, identified R29's mood as unpredictable and the resident could be physically aggressive with cares. In addition, the care plan identified the resident was to wear elbow protectors "as needed" to prevent arm injuries. Despite multiple abrasion areas noted, no other care plan interventions to prevent skin injury were listed.<br><br>Review of facility incident reports revealed there were two reports for R29 which identified the standing lift as a potential source of injury:<br>-Incident report for 1/19/14, identified a small abrasion to the left forearm after toileting at bedtime. Resident may have bumped her arm on the PAL (standing lift).<br>-Incident report for 2/19/14, revealed while staff assisting resident to the bathroom via PAL, resident with behaviors and bumped back of left hand on door frame, obtained laceration. Area was steri-stripped.<br><br>During observation on 4/15/14, at 9:11 a.m. R29 was being transferred onto the toilet using a standing lift being assisted by nursing assistant (NA)-B and NA-A. No elbow protectors were used when R29 was being transferred using a lift.<br><br>During an interview on 4/15/14, at 9:22 a.m., NA-A reported R29 needed elbow protectors on because she had "chicken wings" in the standing | F 280 | transfer of each resident are in place and that staff are following each residents care plan to maintain safety during the transfers. The interventions will be reviewed quarterly and prn with resident changes to assure that all interventions in the residents care plan remain appropriate to maintain the residents' safety.<br><br>The following system changes have taken place since 4/16/14- A new facility investigative form was developed and implemented which includes a review of the incident, interview of staff involved, review of current care plan interventions and discussion of whether changes to care plan interventions should be made. All members of the IDT review and sign off on the incident including the facility administrator Monday through Friday and daily by an RN. The staff follow Vulnerable adult policy and procedure and the administrator is notified immediately of any incidents which are reportable to OHFC.<br><br>If a resident obtains injury from a mechanical transferring device, licensed staff will review care plan and complete investigation to assure that care plan was being followed. If changes or new interventions need to be made, these changes will occur immediately and made known to the direct care staff to prevent further incidents of injury. The IDT will also review each incident to assure that the resident remains safe to use the | |

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| F 280 | Continued From page 68<br>lift, sticking her backside outward and bumped her elbows on the bathroom door frame. NA-A indicated these injuries happened at least once or twice per week.<br><br>During an interview on 4/17/14, at 9:29 a.m., NA-C said R29 was unpredictable with cares and that "you never know what may happen."<br><br>An observation on 4/17/14, at 9:38 a.m. of R29 being transferred to the toilet with the use of a standing lift by NA-H and NA-C. Elbow protectors were not observed on the resident. NA-C left the room and returned with a pair of elbow pads, which were new and still in the wrappers. They were placed on R29 and she was then assisted back to the wheelchair with the standing lift. Elbow protectors had not been observed in the resident's bedroom for use prior to this time.<br><br>An observation of NA-C and NA-H assisting R29 off the toilet on 4/17/14, at 1:28 p.m. was completed. A standing lift was observed being used and R29 appeared to bow her elbows outwards. NA-C manually had to touch R29's elbows to get R29 to bend them inward while going through the bathroom door frame.<br><br>During an interview on 4/17/14, at 1:34 p.m. registered nurse (RN)-A reported R29's care plan directed staff to have arm protectors available for use "as needed" and went on to state the aides just needed to "kind of tell" when she was more combative.<br><br>During interview on 4/17/14, at approximately 3:30 p.m., the director of nursing (DON) indicated that it might be difficult for staff to apply the elbow protectors once the resident was already in the lift | F 280 | mechanical transfer device. A referral to Occupational Therapy will be made if the IDT needs more input or resources to maintain the residents' safety during transfers.<br><br>Risk meetings will be held monthly starting in May 2014, and will have a focus on reviewing incidents/accidents and individual resident care plans. This team will address interventions to keep the resident free from injury. This meeting will continue indefinitely. Any noted trends will be thoroughly reviewed by the team and brought forth and discussed during the facility's QA&A meetings.<br><br>The corrective action for F280 was completed on 6/3/14. | |

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| F 280 | Continued From page 69<br>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.<br><br>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 cause of the accident or incident. | F 280 | F282 Plan of correction 6/3/14<br><br>Resident 14 had skin audit done on 4/24/14 and new injuries were noted. The new incident investigation form was used and reviewed with IDT at that time. Bruising root cause was identified and resident denied staff harm. IDT suggested use of Dermasaver shin protectors to replace sheepskin as well related history of lower extremity bruising and injury. These were ordered on 5/16/14 and will be initiated once arrival to facility. | |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure appropriate protective measures were utilized to prevent bruising in accordance with the plan of care for 1 of 4 residents (R14) reviewed for skin conditions.<br><br>Findings include:<br><br>R14's quarterly Minimum Data Set (MDS) dated 1/16/14, included diagnosis of aphasia and dementia. R14's skin assessment, dated 4/7/14, indicated she did not have any bruising. | F 282 | Care audits have been in place on behavioral residents since 4/21/14. These audits included watching cares and transfers with the mechanical lifs. Upon review on 6/3/14, it was determined that licensed staff will also conduct transfer audits on all residents currently in house using a mechanical lifting device by 6/6/14. Any safety issues noted during the transfer will result in an immediate review by the RN and input will be requested from Occupational therapy. Transfer audits will continue weekly starting week of 6/9/14 and will continue for 60 days. The audits will consist of auditing the transfer of 10 residents a week to assure that all interventions associated with the transfer of each resident are in place and that staff are following each residents care plan to maintain safety during the transfers. The interventions will be reviewed quarterly and prn with resident changes to assure that all interventions in the | |

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| F 282 | Continued From page 70<br>The most recent care plan, dated 1/27/14, directed staff to ensure the resident had sheep skin between her shins and the PAL (standing lift) to prevent skin injuries with transfers.<br><br>R14's wound assessment for the previous three months, January 2014-April 2014, noted two incidents of abrasions on her lower leg. The planned intervention of these assessments were for the staff to use padding to the area, when a lift was used to prevent further injury.<br><br>An observation on 4/15/14, at 9:24 a.m. of nursing assistant (NA)-B lifting R14 onto the bathroom using a standing lift was completed. Sheepskin was not observed in front of R14's shins and the lift, the legs were pressed directly against the leg rests.<br><br>During an interview on 4/15/14, at 9:45 a.m., family member (FM)-A reported she came to the facility every Tuesday and was upset there was no sheepskin in the resident's room to be used to protect her legs in the standing lift. She said she didn't know "where that [sheep skin] went to, some people use it and other people don't." FM-A pointed out bruises on R14's shins, which were brown in color and corresponded to the location her legs would came in contact with, when the standing lift was used.<br><br>NA-C was observed on 4/17/14, at 9:22 a.m. transferring R14 back from the toilet to her 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 | F 282 | residents care plan remain appropriate to maintain the residents' safety.<br><br>The following system changes have taken place since 4/16/14- A new facility investigative form was developed and implemented which includes a review of the incident, interview of staff involved, review of current care plan interventions and discussion of whether changes to care plan interventions should be made. All members of the IDT review and sign off on the incident including the facility administrator. The staff follow Vulnerable adult policy and procedure and the administrator is notified<br><br>immediately of any incidents which are reportable to OHFC.<br><br>If a resident obtains injury from a mechanical transferring device, licensed staff will review care plan and complete investigation to assure that care plan was being followed. If changes or new interventions need to be made, these changes will occur immediately and made known to the direct care staff to prevent further incidents of injury. The IDT will also review each incident to assure that the resident remains safe to use the mechanical transfer device. A referral to Occupational Therapy will be made if the IDT needs more input or resources to maintain the residents' safety during transfers.<br><br>Risk meetings will be held monthly starting in May 2014, and will have a focus on reviewing | |

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| F 282 | Continued From page 71<br>R14's bilateral shins and confirmed bruises were present, and stated she would go tell the nurse.<br><br>The most recent progress note, completed on 4/14/14, did not identify any bruising incidents.<br><br>The facility policy related to skin care entitled Community Memorial Home Wound Treatment Protocol, dated 7/11/05, did not provide specific direction with regard to prevention of bruising or abrasion-type injuries. | F 282 | incidents/accidents and individual resident care plans. This team will address interventions to keep the resident free from injury. This meeting will continue indefinitely. Any noted trends will be thoroughly reviewed by the team and brought forth and discussed during the facility's QA&A meetings.<br><br>The corrective action for F282 was completed on 6/3/14. | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure 2 of 3 residents (R14, R29), reviewed with bruising and skin injuries had individual assessments and interventions in place to ensure bruising/abrasions was prevented.<br><br>Findings include:<br><br>R14 was admitted to the facility on 1/18/08. R14's most recent quarterly Minimum Data Set (MDS), dated 1/16/14, revealed diagnoses of aphasia and dementia. R14's skin assessment, | F 309 | F309 Plan of correction 6/3/14<br><br>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 reviewed and updated on 4/24/14. Care plan was changed from prn to state that resident is to wear the elbow protectors at all times during the day. Dermasaver arm sleeves were ordered and placed on resident on 5/16/14 to decrease incidents of bruising. Care plan was also updated to include these changes. IDT suggested use of Dermasaver shin protectors as well related history of lower extremity bruising and injury. These were ordered on 5/16/14 and will be initiated once arrival to facility. | |

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| F 309 | Continued From page 72<br>dated 4/7/14, revealed she did not have any bruising.<br><br>R14's most recent care plan, dated 1/27/14, indicated the resident was to have sheep skin between her shins and the PAL (standing lift) to prevent skin injuries with transfers.<br><br>Review of R14's wound assessment and monitoring sheets for the last three months revealed two incidents of abrasions on the lower leg, with padding the lift listed as a specific intervention to be used to prevent further injury.<br><br>Observation on 4/15/14, at 9:24 a.m., revealed nursing assistant (NA)-B lifting R14 into the bathroom using a standing lift. No sheepskin was observed in front R14's shins and the lift, the legs were pressed directly against the leg rests.<br><br>During interview on 4/15/14, at 9:45 a.m., family member (FM)-A stated she came to the facility every Tuesday and was upset there was no sheepskin in the resident's room to be used to protect her legs in the standing lift. She said she didn't know "where that went to, some people use and other people don't." FM-A showed surveyor bruises on R14's shins, which were brown in color and corresponded to the location her legs came in contact to the standing lift.<br><br>During observation on 4/17/14, at 9:22 a.m. NA-C transferred R14 back from the toilet to her 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 stated she should be using it to protect R14's legs when being moved with the lift, however, she forgot to use it. NA-C observed | F 309 | Resident 14 had skin audit done on 4/24/14 and new injuries were noted. The new incident investigation form was used and reviewed with IDT at that time. Bruising root cause was identified and resident denied staff harm. IDT suggested use of Dermasaver shin protectors to replace sheepskin as well related history of lower extremity bruising and injury. These were ordered on 5/16/14 and will be initiated once arrival to facility.<br><br>Care audits have been in place on behavioral residents since 4/21/14. These audits included watching cares and transfers with the mechanical lifs. Upon review on 6/3/14, it was determined that licensed staff will also conduct transfer audits on all residents currently in house using a mechanical lifting device by 6/6/14. Any safety issues noted during the transfer will result in an immediate review by the RN and input will be requested from Occupational therapy. Transfer audits will continue weekly starting week of 6/9/14 and will continue for 60 days. The audits will consist of auditing the transfer of 10 residents a week to assure that all interventions associated with the transfer of each resident are in place and that staff are following each residents care plan to maintain safety during the transfers. The interventions will be reviewed quarterly and prn with resident changes to assure that all interventions in the residents care plan | |

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| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET OSAKIS, MN 56360 |

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| F 309 | Continued From page 73<br>R14's bilateral shins and confirmed bruises were present, and stated she would go tell the nurse.<br><br>The facility policy related to skin care entitled Community Memorial Home Wound Treatment Protocol, dated 7/11/05 did not provide specific direction with regard to prevention of bruising or abrasion-type injuries.<br><br>The nursing progress notes revealed a most recent notation made on 4/14/14, that did not address any bruising incidents.<br><br>R29 was admitted to the facility on 2/05/13. R29's current diagnoses, according to her most recent quarterly MDS dated 2/06/14, included psychotic disorder, dementia and anxiety. The MDS also revealed significant cognitive impairment, with both long and short-term memory problems.<br><br>Review of R29's Incident and Wound Assessment reports revealed:<br>-Incident report for 1/19/14, identified a small abrasion to the left forearm after toileting at bedtime. Resident may have bumped her arm on the PAL (standing lift).<br>-Incident report for 2/19/14, revealed that while staff assisting resident to the bathroom via PAL, resident with behaviors and bumped back of left hand on door frame, obtained laceration. Area was steri-stripped.<br><br>R29's care plan, dated 6/19/12, identified R29's mood was unpredictable and could be physically aggressive with cares. In addition, the care plan identified that the resident was to wear elbow protectors as needed to prevent arm injuries. | F 309 | remain appropriate to maintain the residents' safety.<br><br>The following system changes have taken place since 4/16/14- A new facility investigative form was developed and implemented which includes a review of the incident, interview of staff involved, review of current care plan interventions and discussion of whether changes to care plan interventions should be made. All members of the IDT review and sign off on the incident including the facility administrator Monday through Friday and daily by an RN. The staff follow Vulnerable adult policy and procedure and the administrator is notified immediately of any incidents which are reportable to OHFC.<br><br>If a resident obtains injury from a mechanical transferring device, licensed staff will review care plan and complete investigation to assure that care plan was being followed. If changes or new interventions need to be made, these changes will occur immediately and made known to the direct care staff to prevent further incidents of injury. The IDT will also review each incident to assure that the resident remains safe to use the mechanical transfer device. A referral to Occupational Therapy will be made if the IDT needs more input or resources to maintain the residents' safety during transfers. | |

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| F 309 | Continued From page 74<br>Observation on 4/15/14, at 9:11 a.m. revealed R29 being transferred onto the toilet by NA-B and NA-A. No elbow protectors were used during the transfer.<br><br>During interview on 4/15/14, at 9:22 a.m., NA-A stated R29 needed elbow protectors on because she "chicken wings" in the standing lift, sticking her backside outward and bumps her elbows on the bathroom door frame. This happened at least once or twice per week.<br><br>During interview on 4/17/14, at 9:29 a.m. NA-C said R29 was unpredictable with cares and that you never know what may happen.<br><br>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.<br><br>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.<br><br>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 | F 309 | Risk meetings will be held monthly starting in May 2014, and will have a focus on reviewing incidents/accidents and individual resident care plans. This team will address interventions to keep the resident free from injury. This meeting will continue indefinitely. Any noted trends will be thoroughly reviewed by the team and brought forth and discussed during the facility's QA&A meetings.<br><br>The corrective action for F309 was completed on 6/3/14. | |

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| F 309 | Continued From page 75<br>to "kind of tell" when she was more combative. | F 309 | | |
| F 490 SS=F | 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING<br><br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility administrator failed to address a systemic failure related to the lack of identification, investigation, protection, and reporting of alleged violations of potential abuse/mistreatment. This effected 4 of 4 residents (R44, R50, R34, and R53) which resulted in an Immediate Jeopardy (IJ).<br>In addition, the administrator failed to ensure staff providing cares to residents were not disqualified from providing such services for 1 of 1 (NA-D) nursing assistants. The administrator also failed to ensure appropriate screening of potential new employees was completed for 7 of 10 nursing assistants in the sample (NA-I, NA-J, NA-D, NA-E, NA-C, NA-K, & NA-L). The lack of the administrator's involvement in ensuring a facility system to ensure resident protection had the potential to affect 40 of 40 residents who resided in the facility.<br><br>Findings included:<br><br>During an interview on 4/15/14 at 12:10 p.m. the director of nursing (DON) stated she was aware | F 490 | F490 Plan of correction 5/16/14<br><br>Resident 44, 50, 34, and 53 were assessed for bruising on 4/16/14 which was not correlated to any documented incidents. No injuries were noted on residents 44 and 53. Bruising, not correlated with an incident was located on resident 50 and 34 which were immediately filed to OHFC after the facility administrator was updated.<br><br>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 any fracture which is obtained during cares. | |

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| F 490 | Continued From page 76<br>staff needed to restrain combative residents to complete personal cares. The DON stated if a resident is combative or resistive with cares staff should leave the resident safe, and reapproach. DON stated, "The cares have to get done for these residents and there are just some residents who are difficult." She stated when a resident had dementia, there is a risk the resident may be resistive with cares and staff needs to get "cares done as quickly as possible for these residents; you can't just leave them in a soiled brief and not get cares done." DON stated, "There is a point we have to provide cares and I know that residents are held down" by staff to provide the needed cares. DON stated staff were restraining residents for their own safety to make sure the residents were not striking staff or injuring themselves. DON verified injury reports of bruising was documented at times for some residents as related to "combative with cares." She stated this bruising was not suspicious and did not require a full investigation because the facility was aware where the bruising came from and knew the residents weren't being abused. The DON verified the facility did not complete assessments on residents with behaviors or who were combative with cares to ensure individualized interventions were in place; nor did the facility have any investigations or tracking of staff who were providing cares to the residents when they were combative with cares and receiving bruising. DON verified the administrator had no role/involvement/knowledge of the practice of staff holding resident's down to perform personal cares which resulted in resident bruising.<br><br>Background Study<br>The employee filed of NA-D was reviewed. A | F 490 | All residents in the facility were discussed on 4/15/14 and 4/16/14 with both IDT which included the administrator and direct care staff and 4 other residents in the facility were determined to be at a higher risk of obtaining injury related to their combative and aggressive behaviors. These 4 other residents were also assessed on 4/16/14 for injuries which were not documented in an incident report. No new or unexplained injuries were noted.<br><br>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 related to aggressive behaviors had their care plans reviewed and updated on 4/16/14 to include a<br><br>more focused "behavior plan". This plan has resident specific interventions for the direct care staff to use when/if the resident displays aggressive behaviors.<br><br>The nursing assistant who had been disqualified from DHS was suspended without pay on 4/16/14 | |

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| F 490 | Continued From page 77<br>letter was found in the employee file, dated 2/27/14, referencing the background study for NA-D. The letter informed the facility the employee had been disqualified from any position that allowed direct contact with or access to persons who received services from state regulatory agencies. The letter also informed the facility that it may choose to allow the person to provide direct contact services pending a possible reconsideration decision by the Commissioner and if they chose this option they must do the following:<br>· Obtain from the employee a copy of the notice of disqualification which explained the reason for the disqualification;<br>· Ensure the employee requested reconsideration within 30 days of receiving the notice of disqualification and;<br>· Ensure the employee was under continuous, direct supervision when providing direct contact services with persons receiving services from your program, pending reconsideration of the disqualification.<br><br>An interview with human resources (HR)-A was completed on 4/16/14, at 12:02 p.m. HR-A did verify the employee (NA-D) had been employed 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 residents. HR-A verified receiving 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 residents. | F 490 | pending the appeal process and was terminated from employment with the facility on 4/24/14 upon the notification that the appeal had been denied and the employee was disqualified from providing services to persons receiving benefits from DHS.<br><br>As of 5/16/14, all nursing staff have been assigned two education sessions called "Abuse Prevention In Persons with Dementia: The Basics" and "Client Behaviors: Assessment and Intervention in the Resident with Dementia" from the online education system, "Healthcare Academy". The staff have until June 6th, 2014 to complete the required education courses until discipline is enforced by administration.<br><br>The following system changes have taken place since 4/16/14- All staff are aware that they are mandated reporters. The administrator will be notified immediately of any VA reportable incidents per the Vulnerable Adult Policy and Procedure on all days of the week including weekends. A new facility investigative form was developed | |

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

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| F 490 | Continued From page 78<br>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 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).<br>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 employee did not need direct supervision. 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 had 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 residents, independently and behind closed doors. She acknowledged the licensed nurse on duty was to supervise the employee but acknowledged no special plan had been devised | F 490 | 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 an RN. Again, any VA incidents will be reported immediately to the administrator.<br>On 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 by the DON on 4/16/14 to include the addition of individualized "behavior plans" which will be put into place if a resident is at risk of injury related to aggressive behaviors. On 4/17/14 the DON, Administrator and LSW reviewed the facility Vulnerable Adult Policy and Procedure and made multiple changes which include the addition of reference checks, suspension for employees under investigation by DHS, training of new employees with a focus on Alzheimer's/dementia care, staff burnout, and supportive care of the residents during pending | |

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| F 490 | Continued From page 79<br>related to any special supervision for NA-D.<br>An interview with the DON and NA-D was completed on 4/16/14, at 3:05 p.m. During the interview, NA-D reported "had no idea why I was disqualified" and she had contacted Background Division but they would not tell her the rationale over the phone. NA-D adamantly denied she was sent a letter explaining the rationale for the disqualification. NA-D reported she needed to provide FBI fingerprints, letters of recommendations from the DON, her direct supervisor, and two of her coworkers in order for the agency to reconsider the disqualification. She reported she obtained these items and mailed them on 3/7/14, and provided a receipt of the letter mailed to the DON, after which she was allowed to return to work. She indicated she returned under supervision of the LPN on duty and used the buddy system with the two other staff that she worked with. NA-D indicated the "buddy system" meant the nursing assistants cared for a group of residents they were assigned to and that she did not need "a babysitter." She reported she could and did independently care for residents, with no special limitations. She verified it was acceptable for her to independently provide cares to residents, in their rooms with door closed and she was under no special supervision.<br><br>An interview with the administrator was 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 | F 490 | 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 all incidents need to be thoroughly investigated to find root cause and to assure that the investigation component is complete. If abuse has been suspected, a Vulnerable Adult report will be submitted immediately.<br><br>The administrator and DON have been meeting daily when able since 4/22/14 during the work week to review and discuss the ongoing audits, trends, cares, and incidents and daily happenings at the nursing home. The administrator has been keeping a log of these meetings.<br><br>Risk meetings will be held monthly starting in May 2014, and will have a focus on reviewing | |

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| F 490 | Continued From page 80<br>and they jointly made the decision to allow the employee to return to work during the appeal process. When asked as to the definition of "continuous direct supervision," he did not respond.<br><br>Reference checks<br>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.<br><br>An interview with the DON was completed on 4/17/14 at 9:20 a.m. She reported she was responsible to check potential employee's references and should have done this for the any employee they were considering hiring. She was unable to provide evidence that these employees' references had been checked.<br><br>No indication was given related to the role of the administrator during the hiring process or his expectations of such.<br><br>Quality Assurance<br>An interview on 4/17/14, at 3:52 p.m. was completed with the DON regarding the Quality Assurance Committee, which the Administrator is a member. The DON indicated she made a list of the number of incidents which are shared with the committee, however, specific incidents are not discussed. The DON indicated the Quality Assurance Committee had "never really questioned" the number or type of incidents and injuries, or the nature of those incidents. The administrator did not review the incident reports to obtain specific information related to resident injury or accidents. | F 490 | incidents/accidents and individual resident care plans to address behavior plans and interventions. The administrator will attend this mtg and if unable to attend, administrator will be given verbal summary of the mtg. This meeting will continue indefinitely and the trends developed by this team will be brought forth and discussed during the facility's QA&A meetings. The DON will also start to bring the facility incident reports with to the QA&A meetings. This will allow review of the incident and investigation, including staff interviews and conclusion of root cause to be discussed and reviewed by the QA&A members.<br><br>Corrective action for F490 was completed on 5/16/14 | |

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| F 520<br>F 520<br>SS=F | Continued From page 81<br>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS<br><br>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.<br><br>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.<br><br>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.<br><br>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility's Quality Assessment and Assurance (QA&A) committee failed to identify quality concerns related to resident injuries and bruising of unknown origin and potential staff abuse. This had the potential to effect 40 of 40 residents currently residing in the facility. | F 520<br>F 520 | F520 Plan of correction on 5/16/14<br><br>Beginning with the next scheduled meeting of the Quality Assessment & Assurance committee (QA & A), the Administrator, who functions as the Coordinator and monitor of QA & A activities, will ensure that currently identified quality concerns and the plan of correction related to resident injuries, bruising of unknown origin, and the potential for abuse by staff is brought to the attention of committee members for their review and consideration. Specifically, QA & A committee members will review any and all remedial actions that have been taken with regard to affected residents since deficient practices were identified on 4-15-14. These remedial actions have included review and revision of nursing assessment and audit procedures, OHFC reporting, changes to our Vulnerable Adult Abuse & Neglect prevention plan, active participation by IDT and risk committee members, staff (re)education efforts, revisions to resident care and behavior plans, the identification of appropriate staff interventions, and revised procedures concerning employee background and reference checks. In addition, the QA & A committee will review all incidents, investigations, and trends, if any, for consideration in their development and implementation of additional and | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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|---|---|---|---|---|
| F 520 | Continued From page 82<br>Findings include:<br><br>Refer to F223 as the facility failed to promote and enforce a resident environment that was free from physical abuse for 4 of 4 residents, (R44, R50, R34, R53) who exhibited combative behaviors. The failure of the facility to ensure combative residents were assessed and monitored to ensure appropriate interventions were in place and being implemented by staff, and the lack of investigation and oversight of staff who identified restraining residents while providing cares which resulted in bruising to the residents, resulted in an immediate jeopardy (IJ) on 4/15/14, at 4:47 p.m. for R44, R50, R34, and 53 who were identified by staff as residents who were combative with cares which required staff to restrain them.<br><br>Refer to F225/F226 as the facility failed to ensure resident injuries and injuries/bruising of unknown origin and potential staff abuse were thoroughly investigated and reported to the administrator and state agency for 5 of 6 residents, (R44, R50, R34, R53, and R16) who experienced injuries of unknown origin, potential staff abuse, and/ or injury resulting from staff providing cares. The facility Vulnerable Adult Policy and Procedure/ Prevention Plan lacked instruction on protecting the resident during an investigation, how staff will be supervised during an investigation, definition and identifying staff burnout, training on how to deal with resident aggression, and obtaining reference checks on employees before beginning employment.<br><br>During an interview on 4/17/14, at 3:52 p.m., DON indicated the QA&A meetings are held | F 520 | appropriate plans of action to correct identified quality deficiencies. Oversight and monitoring from the QA & A Committee will continue indefinitely. In future meetings of the QA & A Committee, the Coordinator/Administrator will solicit concerns about quality from each and every committee member representing the full spectrum of services provided to Community Memorial Home residents. Follow-up on quality improvement plans that have been developed by or at the request of the QA & A Committee will be monitored for effectiveness by the Coordinator and reported at all subsequent QA & A meetings. The next QA & A meeting has been tentatively scheduled for 6-17-14.<br><br>The corrective action for F520 was completed on 5/16/14 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245465 | A. BUILDING _____ B. WING _____ | 04/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 520 | Continued From page 83<br>quarterly. DON indicated she makes a list of the number of incidents and falls which is shared with the committee, however, specific incidents are not discussed. DON indicated the QA&A committee has "never really questioned" the number of incidents and injuries, or the nature of those incidents. | 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, F225, 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.

Jessica Fellman 6/3/14

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245465 | A. BUILDING 02 - 2 BLDG PT/OT WELLNESS CENTER<br>B. WING _____ | 04/16/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET<br>OSAKIS, MN 56360 |

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|---|---|---|---|---|
| K 000 | INITIAL COMMENTS | K 000 | | |

FIRE SAFETY

DE: 5-27-14

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.

5-23-14

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.

EXIT: 4-17-14

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.

RECEIVED
MAY 20 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Sharon E. Carlson | Administrator | May 16, 2014 |

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

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

F5465023

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 CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245465 | A. BUILDING **01 - MAIN BUILDING 01** B. WING _____ | **04/16/2014** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **COMMUNITY MEMORIAL HOME** | **410 WEST MAIN STREET OSAKIS, MN 56360** |

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|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>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.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, 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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>HEALTH CARE FIRE INSPECTIONS<br>STATE FIRE MARSHAL DIVISION<br>444 CEDAR STREET, SUITE 145<br>ST. PAUL, MN 55101-5145, or | K 000 | K 067- A waiver continuation for K 067 is being requested for which justification dated 5/14/2014 on form CMS 2786R is attached.<br><br>POC ok<br>w/AW for K 67<br>5-03-14<br><br>RECEIVED<br>MAY 20 2014<br>MN DEPT. OF PUBLIC SAFETY<br>STATE FIRE MARSHAL DIVISION | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 5-16-14

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.

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 CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245465 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **04/16/2014** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **COMMUNITY MEMORIAL HOME** | **410 WEST MAIN STREET**<br>**OSAKIS, MN 56360** |

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|---|---|---|---|---|
| K 000 | Continued From page 1<br>By e-mail to:<br>Marian.Whitney@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>This facility was surveyed as two separate buildings. Community Memorial Home is a 2 story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1963, is one story and was determined to be of Type II(000) construction. In 1977, a one story, Type II(000), expansion to the dining room was added. Because the original 1963 building and the 1977 addition meet the construction type allowed for existing buildings, these buildings were surveyed as one existing building. The 2 story 2008 Wellness Center addition was surveyed as new construction.<br><br>The building is fully fire sprinklered throughout. The facility 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 facility has a capacity of 50 beds and had a census of 40 at the time of the survey. | K 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245465 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **04/16/2014** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|---|---|---|
| K 000 | Continued From page 2<br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 067<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation..<br><br>Findings include:<br><br>During the facility tour between 9:00 AM and 12:00 PM on 04/16/14, an interview with the Facility Administrator (DC), a review of documentation and observations revealed that the HVAC systems for all wings of the 1963 and 1977 additions have ducted air supply to the corridors and no return or exhaust from the corridors. There is no supply or return in the resident rooms, which all have bathroom exhaust fans that are constantly exhausting to the outside. This situation is using the corridors as a supply | K 067 | See page one | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245465 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **04/16/2014** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **COMMUNITY MEMORIAL HOME** | **410 WEST MAIN STREET**<br>**OSAKIS, MN 56360** |

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|---|---|---|---|---|
| K 067 | Continued From page 3<br>plenum.<br><br>This was confirmed by the Director of Environmental Services (TM)<br><br>An annual waiver has been previously granted. | K 067 | | |

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL** — ID: 5L8E

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY** — Facility ID: 00109

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245465**

2.STATE VENDOR OR MEDICAID NO.
(L2) **668340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **COMMUNITY MEMORIAL HOME**
(L4) **410 WEST MAIN STREET**
(L5) **OSAKIS, MN** (L6) **56360**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/17/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

| | | | | |
|---|---|---|---|---|
| 01 Hospital | 05 HHA | 09 ESRD | 13 PTIP | 22 CLIA |
| 02 SNF/NF/Dual | 06 PRTF | 10 NF | 14 CORF | |
| 03 SNF/NF/Distinct | 07 X-Ray | 11 ICF/IID | 15 ASC | |
| 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | |

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

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 50 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

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

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

17. SURVEYOR SIGNATURE — Date :
LoAnn DeGagne, HFE NE II — 06/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 06/19/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
**04/01/1987**
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

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

30. REMARKS
AW K67 Emailed CMS 06/20/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

F5465023

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

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|---|---|---|---|
| | 245465 | A. BUILDING **01 - MAIN BUILDING 01** B. WING _____ | **04/16/2014** |

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|---|---|
| **COMMUNITY MEMORIAL HOME** | **410 WEST MAIN STREET OSAKIS, MN 56360** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>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.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, 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.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>HEALTH CARE FIRE INSPECTIONS<br>STATE FIRE MARSHAL DIVISION<br>444 CEDAR STREET, SUITE 145<br>ST. PAUL, MN 55101-5145, or | K 000 | K 067- A waiver continuation for K 067 is being requested for which justification dated 5/14/2014 on form CMS 2786R is attached.<br><br>POC ok<br>w/AW for K 67<br>5-03-14<br><br>RECEIVED<br>MAY 20 2014<br>MN DEPT. OF PUBLIC SAFETY<br>STATE FIRE MARSHAL DIVISION | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 5-16-14

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| K 000 | Continued From page 1<br>By e-mail to:<br>Marian.Whitney@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>This facility was surveyed as two separate buildings. Community Memorial Home is a 2 story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1963, is one story and was determined to be of Type II(000) construction. In 1977, a one story, Type II(000), expansion to the dining room was added. Because the original 1963 building and the 1977 addition meet the construction type allowed for existing buildings, these buildings were surveyed as one existing building. The 2 story 2008 Wellness Center addition was surveyed as new construction.<br><br>The building is fully fire sprinklered throughout. The facility 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 facility has a capacity of 50 beds and had a census of 40 at the time of the survey. | K 000 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| K 000 | Continued From page 2<br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 067<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation..<br><br>Findings include:<br><br>During the facility tour between 9:00 AM and 12:00 PM on 04/16/14, an interview with the Facility Administrator (DC), a review of documentation and observations revealed that the HVAC systems for all wings of the 1963 and 1977 additions have ducted air supply to the corridors and no return or exhaust from the corridors. There is no supply or return in the resident rooms, which all have bathroom exhaust fans that are constantly exhausting to the outside. This situation is using the corridors as a supply | K 067 | See page one | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245465 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **04/16/2014** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **COMMUNITY MEMORIAL HOME** | **410 WEST MAIN STREET**<br>**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 067 | Continued From page 3<br>plenum.<br><br>This was confirmed by the Director of Environmental Services (TM)<br><br>An annual waiver has been previously granted. | K 067 | | |

## 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 Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

**Name of Facility**

Community Memorial Home (CMH) at Osakis, MN Inc.

**2000 CODE**

**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<br>K067<br><br>Heating, Ventilation and Air Conditioning (HVAC) equipment at CMH does not comply with LSC (00) Section 9.2 and NFPA 90A, 1999 Edition because the corridors are used as a plenum. | A continuing waiver is being requested for K067 for the following reasons:<br>A. An extreme financial hardship on Community Memorial Home(CMH) will result from compliance because:<br>1. Revised estimates (5-14-14, attached) show that compliance with NFPA 90A will cost between $446,120 and $579,299. These dollars are not available under current reimbursement rules;<br>2. The electrical system at CMH would need to be modified at a cost that may exceed $42,000;<br>3. Asbestos abatement during installation would cost between $59,483 and $81,900; and<br>4. Non-complying systems are allowed to be used under LSC(00), 9.2.1.<br>B. If this waiver is approved, the safety of building occupants will not be compromised because:<br>1. CMH was built under Type II construction standards;<br>2. Walls, floors, ceilings and vertical openings at CMH already resist the passage of smoke;<br>3. CMH is completely protected by a supervised sprinkler system installed in accordance with NFPA 13;<br>4. HVAC ventilation fans automatically shut down upon activation of a fire alarm or upon detection of smoke;<br>5. Resident sleeping rooms are all equipped with single station battery operated smoke detectors;<br>6. The property of CMH is smoke and tobacco free with signs posted to that effect;<br>7. All CMH Corridors are equipped with a compliant UL listed smoke detection system;<br>8. The local fire department is located 6 blocks away and can respond to an alarm in less than 10 mins.;<br>9. CMH has an approved fire safety plan and is compliant with all other fire safety requirements; and<br>10. A continuing waiver has been approved annually in the past for Community Memorial.<br><br>Requested by: David E. Carlson Administrator 5-14-2014<br>David E. Carlson, Administrator 5-14-2014 |

| Surveyor *(Signature)* | Title | Office | Date |
|---|---|---|---|
| Fire Authority Official *(Signature)* | Title Fire Safety Supervisor | Office State Fire Marshal | Date 5-23-14 |


3315 Roosevelt Road, Ste. 100
St. Cloud MN 56301
Bus. (320) 251-0262 Fax: (320) 251-5749

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

| | | Low Range 24,000 S.F. | | High Range 24,000 S.F. | |
|---|---|---|---|---|---|
| | | DOLLARS | | DOLLARS | |
| ***I. LAND*** | ***SUBTOTAL LAND*** | $ - | | $ - | |
| ***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 | | $ 5,305 | $ 0.22 | $ 10,816 | $ 0.45 |
| ELECTRICAL | | $ 37,132 | $ 1.55 | $ 43,264 | $ 1.80 |
| CONTINGENCY | | $ 30,000 | $ 1.25 | $ 38,000 | $ 1.58 |
| | ***SUBTOTAL CONSTRUCTION COSTS*** | $ 321,748 | $ 13.41 | $ 413,315 | $ 17.22 |
| ***III. SOFT COSTS*** | | | | | |
| FEES / PERMITS / PRINTING | | $ 64,890 | $ 2.70 | $ 84,084 | $ 3.50 |
| OTHER | | $ - | $ - | $ - | $ - |
| | ***SUBTOTAL SOFT COSTS*** | $ 64,890 | $ 2.70 | $ 84,084 | $ 3.50 |
| ***IV. OWNER ITEMS*** | | | | | |
| FURNITURE/FIXTURES/EQUIPMENT | | $ - | | $ - | |
| OTHER - ASBESTOS ABATEMENT | | $ 59,483 | $ 2.48 | $ 81,900 | $ 3.41 |
| | ***SUBTOTAL OWNER ITEMS COSTS*** | $ 59,483 | $ 2.48 | $ 81,900 | $ 3.41 |
| ***V. TOTAL PROJECT COST*** | | $ 446,120 | $ 18.59 | $ 579,299 | $ 24.14 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245465 | A. BUILDING 02 - 2 BLDG PT/OT WELLNESS CENTER<br>B. WING _____ | 04/16/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| COMMUNITY MEMORIAL HOME | 410 WEST MAIN STREET<br>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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS | K 000 | | |

FIRE SAFETY

DE: 5-27-14

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.

5-23-14

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.

EXIT: 4-17-14

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.

RECEIVED
MAY 20 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Sharon E. Carlson | Administrator | May 16, 2014 |

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

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

F5465023

**2000 CODE**

Form Approved
OMB Exempt

# FIRE SAFETY SURVEY REPORT 2000 CODE - HEALTH CARE
## Medicare – Medicaid

| 1. (A) PROVIDER NUMBER | 1. (B) MEDICAID I.D. NO. |
|---|---|
| K1 245465 | K2 |

PART I — Life Safety Code, New and Existing
PART IV — Waiver Recommendation Form

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

| 2. NAME OF FACILITY | 2. (A) MULTIPLE CONSTRUCTION (BLDGS) | 2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE) | |
|---|---|---|---|
| Community Memorial Home | A. BUILDING Bldg. 01<br>B. WING<br>C. FLOOR<br>K3 | 410 West Main Street<br>Osakis, MN 56360 | A. (●) Fully Sprinklered (All required areas are sprinklered)<br>B. ( ) Partially Sprinklered (Not all required areas are sprinklered)<br>C. ( ) None (No sprinkler system)<br>K0180 |

| 3. SURVEY FOR | 4. DATE OF SURVEY | DATE OF PLAN APPROVAL | SURVEY UNDER |
|---|---|---|---|
| [✓] MEDICARE [✓] MEDICAID | K4 04/16/2014 | K6 | 5. [✓] 2000 EXISTING 6. [ ] 2000 NEW K7 |

5. SURVEY FOR CERTIFICATION OF

1. ( ) HOSPITAL 2. (●) SKILLED/NURSING FACILITY 4. ( ) ICF/MR UNDER HEALTH CARE 5. ( ) HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW

1. [ ] ENTIRE FACILITY 2. ( ) DISTINCT PART OF (SPECIFY) _____

3. [ ] IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?
a. ( ) YES b. (●) NO

| 6. BED COMPOSITION | | | | |
|---|---|---|---|---|
| a. TOTAL NO. OF BEDS IN THE FACILITY 50 | b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE 0 | c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE 50 | d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID 50 | e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID 0 |

7. A. (●) THE FACILITY MEETS, BASED UPON (CHECK ALL APPROPRIATE BOXES)

1. ( ) COMPLIANCE WITH ALL PROVISIONS 2. (●) ACCEPTANCE OF A PLAN OF CORRECTION 3. ( ) RECOMMENDED WAIVERS 4. ( ) LSES 5. ( ) PERFORMANCE BASED DESIGN

B. ( ) THE FACILITY DOES NOT MEET THE STANDARD

K9

| SURVEYOR (Signature) | TITLE | OFFICE | DATE |
|---|---|---|---|
| James Anderson<br>SURVEYOR ID 27200 K10 | Deputy State Fire Marshal | State Fire Marshal | 04/16/2014 |
| FIRE AUTHORITY OFFICIAL (Signature) | TITLE | OFFICE | DATE |
| [signature] | Fire Safety Supervisor | State Fire Marshal | 4-21-14 |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | **PART I - LSC REQUIREMENTS** - Items in italics relate to the FSES | | | | K 12<br>This facility was surveyed as two separate buildings. Community Memorial Home is a 2 story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1963, is one story and was determined to be of Type II(000) construction. In 1977, a one story, Type II(000), expansion to the dining room was added. Because the original 1963 building and the 1977 addition meet the construction type allowed for existing buildings, these buildings were surveyed as one existing building. The 2 story 2008 Wellness Center addition was surveyed as new construction. |
| | **BUILDING CONSTRUCTION** | | | | |
| K11 | If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1½ hour fire resistance rating<br>18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 | ○ | ○ | ○ | |
| K12 | 2000 EXISTING<br>Building construction type and height meets one of the following:<br>19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 | ○ | ○ | ○ | |
| | 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) — Not over two stories with complete automatic sprinkler system. | | | | |
| | 5 ○ V (111) — Not over two stories with complete automatic sprinkler system. | | | | |
| | 6 ○ IV (2HH) — Not over two stories with complete automatic sprinkler system. | | | | |
| | 7 ○ II (000) — Not over two stories with complete automatic sprinkler system. | | | | |
| | 8 ○ III (200) — Not over one story with complete automatic sprinkler system. | | | | |
| | 9 ○ V (000) — Not over one story with complete automatic sprinkler system. | | | | |
| | ☐ Building contains fire treated wood.<br>*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.* | | | | |

| ID PREFIX | | | | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|---|---|---|
| K12 | 2000 NEW<br>Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.3.5.1. | | | | | | | |
| | 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) | Not over one story with complete automatic sprinkler system. | | | | |
| | 4 | | V (111) | | | | | |
| | 5 | | IV (2HH) | | | | | |
| | 6 | | II (000) | | | | | |
| | 7 | | III (200) | Not Permitted | | | | |
| | 8 | | V (000) | | | | | |
| | ☐ Building contains fire treated wood.<br>*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 | Interior walls and partitions in buildings of Type I or Type II construction shall be noncombustible or limited-combustible materials. 18.1.6.3, 19.1.6.3<br>(Indicate N/A for existing buildings using listed fire retardant treated wood studs within non-load bearing one-hour rated partitions.) | | | | ○ | ○ | ○ | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | **INTERIOR FINISH** | | | | |
| K14 | 2000 EXISTING<br>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 1/28 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<br>*Indicate flame spread rating/s* A | ○ | ○ | | |
| | 2000 NEW<br>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<br>*Indicate flame spread rating/s*_____ | | | | |
| K15 | 2000 EXISTING<br>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<br>*Indicate flame spread rating/s* A | ○ | ○ | | |
| | 2000 NEW<br>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.<br>*Indicate flame spread rating/s*_____ | | | | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| K16 | 2000 EXISTING<br>Newly installed interior floor finish complying with 10.2.7 shall be permitted in corridors and exits if Class I. 19.3.3.3<br>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** | | | | |
| K17 | 2000 EXISTING<br>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.)<br>19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5<br>*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<br>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.<br>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<br>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 | ○ | ○ | | |
| | *Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.* | | | | |
| | 2000 NEW<br>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).<br>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<br>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<br>*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<br>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:<br>☐ (a) The required manual fire alarm system and<br>☐ (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and<br>☐ (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<br>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1<br>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. | ○ | ○ | ○ | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | Describe method used in REMARKS | | | | |
| | **SMOKE COMPARTMENTATION AND CONTROL** | | | | |
| K23 | 2000 EXISTING<br>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<br>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<br>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<br>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 | ○ | ○ | ○ | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| K27 | 2000 EXISTING<br>Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 | ○ | ○ | ○ | |
| | 2000 NEW<br>Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8 | | | | |
| K28 | 2000 EXISTING<br>Door openings in smoke barriers shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors. 19.3.7.7 | ○ | ○ | ○ | |
| | 2000 NEW<br>Door openings in smoke barriers are installed as swinging or horizontal doors shall provide a minimum clear width as follows:<br>Provider Type / Swinging Doors / Horizontal Sliding Doors<br>Hospitals and Nursing Facilities / 41.5 inches (105 cm) / 83 inches (211 cm)<br>Psychiatric Hospitals and Limited Care Facilities / 32 inches (81 cm) / 64 inches (163 cm)<br>18.3.7.7 | | | | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| K104 | 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** | | | | |
| K29 | 2000 EXISTING<br>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. 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 | ✔ | ✔ | |

*Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.*

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | 2000 NEW<br>Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a ¾ 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. | | | | |
| 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 not considered hazardous, have separate protected storage and that are completely sprinkled. Gift shops may be open to the corridor 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 |
|---|---|---|---|
| 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 | | | |
| m. Combustible Storage Rooms/Spaces (over 100 sq feet) | | | |

*Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.*

| Area | Automatic Sprinkler | Separation | N/A |
|---|---|---|---|
| L. Gift Shop storing hazardous quantities of combustibles | ☐ | ☐ | ☐ |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| K211 | Where Alcohol Based Hand Rub (ABHR) dispensers are installed:<br>☑ The corridor is at least 6 feet wide<br>☑ The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)<br>☑ The dispensers shall have a minimum spacing of 4 ft from each other<br>☑ Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.<br>☑ Dispensers are not installed over or adjacent to an ignition source.<br>☑ If the floor is carpeted, the building is fully sprinklered.<br>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<br>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<br>*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.* | | | | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | 2000 NEW<br>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.<br>• Room door to exit ≤ 100 ft (≤ 150 ft sprinklered)<br>• Point in room or suite to exit ≤ 150 ft (≤ 200 ft sprinklered)<br>• Point in room to room door ≤ 50 ft<br>• Point in suite to suite door ≤ 100 ft<br>18.2.6, 19.2.6 | ○ | ○ | | |
| K37 | 2000 EXISTING<br>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<br>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<br>Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3 | ○ | ○ | | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | 2000 NEW<br>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<br>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<br>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<br>*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.<br>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*<br>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<br>(Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) | ○ | ○ | ○ | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| 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)<br>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** | | | | |
| 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 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)<br>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 | ○ | ○ | ○ | |
| | | | | | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | 2000 NEW (NURSING HOME AND EXISTING LIMITED CARE FACILITIES)<br>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)<br>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<br>Smoke Detection System<br>☐ Corridors<br>☐ Rooms<br>☐ Bath | ○ | ○ | ◉ | |
| 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<br>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<br>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 PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | 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 | | | | |
| K60 | 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** | | | | |
| K56 | 2000 EXISTING<br>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<br>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. | | | | |
| K154 | 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. 04/17/2013 | | | | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | B. Show who provided the service. Summitt Fire Protection | | | | |
| | C. Note the source of water supply for the automatic sprinkler system. City Water Supply | | | | |
| | *(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)<br>(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 international symbol for no smoking.<br>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) | ○ | ○ | ○ | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | (2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision.<br>(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.<br>(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. | | | | K67<br>Based on observations and an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation..<br><br>Findings include:<br><br>During the facility tour between 9:00 AM and 12:00 PM on 04/16/14, an interview with the Facility Administrator (DC), a review of documentation and observations revealed that the HVAC systems for all wings of the 1963 and 1977 additions have ducted air supply to the corridors and no return or exhaust from the corridors. There is no supply or return in the resident rooms, which all have bathroom exhaust fans that are constantly exhausting to the outside. This situation is using the corridors as a supply plenum.<br><br>This was confirmed by the Director of Environmental Services (TM)<br><br>An annual waiver has been previously granted. |
| | **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.<br>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.<br>18.5.2.2, 19.5.2.2. | | | | |
| K69 | Cooking facilities shall be protected in accordance with 9.2.3.<br>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).<br>18.7.8, 19.7.8 | | | | |
| K71 | Rubbish Chutes, Incinerators and Laundry Chutes.<br>18.5.4, 19.5.4, 9.5, 8.4, NFPA 82<br>(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.<br>(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.<br>(3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. | | | | |

| ID 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<br>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.<br>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<br>(Includes firefighters service **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) | ○ | ○ | ○ | |
| | 2000 NEW<br>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.<br>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<br>(Includes firefighters service **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) | | | | |
| K161 | 2000 EXISTING<br>Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.<br>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 | ○ | ○ | ● | |

| 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<br>Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.<br>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** | | | | |
| K73 | 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 | ○ | ○ | ○ | |
| K74 | 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<br>☐ 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.<br>☐ 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<br>☐ Newly introduced upholstered furniture and mattresses means purchased since March, 2003. | ○ | ○ | ○ | |
| K75 | 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/ft$^2$ (20.4 L/m$^2$). A | ○ | ○ | ○ | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | capacity of 32 gal (121 L) shall not be exceeded within any 64-ft$^2$ (5.9-m$^2$) 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 | ○ | ○ | ○ | |
| | **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 PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | 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 | Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.<br>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.<br>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside.<br>4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 | ○ | ○ | ○ | |
| K77 | Piped in medical gas, vacuum and waste anesthetic gas disposal systems comply with NFPA 99, Chapter 4. | ○ | ○ | ○ | |
| K78 | Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.<br>(a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others.<br>(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 | ○ | ○ | ○ | |
| K140 | Medical gas warning systems shall be in accordance with NFPA 99, Standard for Health Care Facilities.<br>(a) Master alarm panels are in two separate locations and have audible and visible signals.<br>(b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4-3.1.2.2<br>(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.<br>4-3.1.2.2 (NFPA 99) | ○ | ○ | ○ | |
| 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:<br>CAUSION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99) | ○ | ○ | ○ | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| K142 | All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19. | ○ | ○ | ○ | |
| K143 | Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows::<br>(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<br>(b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and<br>(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.<br>8-6.2.5.2 (NFPA 99) | ○ | ○ | ○ | |
| | **ELECTRICAL AND EMERGENCY POWER** | | | | |
| K106 | 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) | ○ | ○ | ○ | |
| K107 | Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72.<br>9.6.1.4, 18.3.4.1, 19.3.4.1 | ○ | ○ | | |
| K108 | 2000 NEW (INDICATE N/A FOR EXISTING)<br>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 | | | ☑ | |
| K144 | Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110.<br>3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) | ○ | ○ | ○ | |
| K145 | 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 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<br>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 | Office | Date |
|---|---|---|---|
| Fire Authority Official *(Signature)* | Title | Office | Date |

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

F5465023

**2000 CODE**

Form Approved
OMB Exempt

# FIRE SAFETY SURVEY REPORT 2000 CODE - HEALTH CARE
## Medicare – Medicaid

| 1. (A) PROVIDER NUMBER | 1. (B) MEDICAID I.D. NO. |
|---|---|
| K1 245465 | K2 |

PART I — Life Safety Code, New and Existing
PART IV — Waiver Recommendation Form

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

| 2. NAME OF FACILITY | 2. (A) MULTIPLE CONSTRUCTION (BLDGS) | 2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE) | |
|---|---|---|---|
| Community Memorial Home | A. BUILDING Bldg 02<br>B. WING<br>C. FLOOR<br>K3 | 410 West Main Street<br>Osakis, MN 56360 | A. (●) Fully Sprinklered (All required areas are sprinklered)<br>B. ( ) Partially Sprinklered (Not all required areas are sprinklered)<br>C. ( ) None (No sprinkler system)<br>K0180 |

| 3. SURVEY FOR | 4. DATE OF SURVEY | DATE OF PLAN APPROVAL | SURVEY UNDER |
|---|---|---|---|
| [✓] MEDICARE [✓] MEDICAID | 04/16/2014<br>K4 | K6 | 5. [ ] 2000 EXISTING 6. [✓] 2000 NEW<br>K7 |

5. SURVEY FOR CERTIFICATION OF

1. ( ) HOSPITAL 2. (●) SKILLED/NURSING FACILITY 4. ( ) ICF/MR UNDER HEALTH CARE 5. ( ) HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW

1. [ ] ENTIRE FACILITY 2. (●) DISTINCT PART OF (SPECIFY) _____

3. [ ] IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?
a. ( ) YES b. (●) NO

| 6. BED COMPOSITION<br>a. TOTAL NO. OF BEDS IN THE FACILITY | b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE | c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE | d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID | e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID |
|---|---|---|---|---|
| 50 | 0 | 50 | 50 | 0 |

7. A. (●) THE FACILITY MEETS, BASED UPON (CHECK ALL APPROPRIATE BOXES)
1. (●) COMPLIANCE WITH ALL PROVISIONS 2. ( ) ACCEPTANCE OF A PLAN OF CORRECTION 3. ( ) RECOMMENDED WAIVERS 4. ( ) FSES 5. ( ) PERFORMANCE BASED DESIGN

B. ( ) THE FACILITY DOES NOT MEET THE STANDARD
K9

| SURVEYOR *(Signature)* | TITLE | OFFICE | DATE |
|---|---|---|---|
| James Anderson<br>SURVEYOR ID 27200<br>K10 | Deputy State Fire Marshal | State Fire Marshal | 04/16/2014 |
| FIRE AUTHORITY OFFICIAL *(Signature)* | TITLE | OFFICE | DATE |
| | Fire Safety Supervisor | State Fire Marshal | 4-21-14 |

| ID PREFIX | | | | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|---|---|---|
| | **PART I - LSC REQUIREMENTS** - Items in italics relate to the FSES | | | | | | | K 12<br>This facility was surveyed as two separate buildings. Community Memorial Home is a 2 story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1963, is one story and was determined to be of Type II(000) construction. In 1977, a one story, Type II(000), expansion to the dining room was added. Because the original 1963 building and the 1977 addition meet the construction type allowed for existing buildings, these buildings were surveyed as one existing building. The 2 story 2008 Wellness Center addition was surveyed as new construction. |
| | **BUILDING CONSTRUCTION** | | | | | | | |
| K11 | If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1½ hour fire resistance rating<br>18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 | | | | ○ | ○ | ○ | |
| K12 | 2000 EXISTING<br>Building construction type and height meets one of the following:<br>19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 | | | | | | | |
| | 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) | Not over two stories with complete automatic sprinkler system. | | | | |
| | 5 | | V (111) | | | | | |
| | 6 | | IV (2HH) | | | | | |
| | 7 | | II (000) | | | | | |
| | 8 | | III (200) | Not over one story with complete automatic sprinkler system. | | | | |
| | 9 | | V (000) | | | | | |
| | ☐ Building contains fire treated wood.<br>*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.* | | | | | | | |

| ID PREFIX | | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|---|
| K12 | 2000 NEW<br>Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.3.5.1. | | ○ | ○ | ○ | |
| | 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) | Not over one story with complete automatic sprinkler system. | | | | |
| | 4 ○ V (111) | | | | | |
| | 5 ○ IV (2HH) | | | | | |
| | 6 ○ II (000) | | | | | |
| | 7 ○ III (200) | Not Permitted | | | | |
| | 8 ○ V (000) | | | | | |
| | ☐ Building contains fire treated wood.<br>*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 | Interior walls and partitions in buildings of Type I or Type II construction shall be noncombustible or limited-combustible materials. 18.1.6.3, 19.1.6.3<br>(Indicate N/A for existing buildings using listed fire retardant treated wood studs within non-load bearing one-hour rated partitions.) | | ○ | ○ | ○ | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | **INTERIOR FINISH** | | | | |
| K14 | 2000 EXISTING<br>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 1/28 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<br>*Indicate flame spread rating/s* _____ | | | | |
| | 2000 NEW<br>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<br>*Indicate flame spread rating/s* A | ○ | ○ | | |
| K15 | 2000 EXISTING<br>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<br>*Indicate flame spread rating/s*_____ | | | | |
| | 2000 NEW<br>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.<br>*Indicate flame spread rating/s* A | ○ | ○ | | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| K16 | 2000 EXISTING<br>Newly installed interior floor finish complying with 10.2.7 shall be permitted in corridors and exits if Class I. 19.3.3.3<br>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** | | | | |
| K17 | 2000 EXISTING<br>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.)<br>19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5<br>*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<br>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.<br>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<br>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 | | | | |
| | *Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.* | | | | |
| | 2000 NEW<br>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).<br>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<br>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<br>*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<br>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:<br>☐ (a) The required manual fire alarm system and<br>☐ (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and<br>☐ (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<br>Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1<br>Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. | ○ | ○ | ○ | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | Describe method used in REMARKS | | | | |
| | **SMOKE COMPARTMENTATION AND CONTROL** | | | | |
| K23 | 2000 EXISTING<br>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<br>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<br>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<br>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 | ○ | ○ | ○ | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| K27 | 2000 EXISTING<br>Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 | | | | |
| | 2000 NEW<br>Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8 | ○ | ○ | ○ | |
| K28 | 2000 EXISTING<br>Door openings in smoke barriers shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors. 19.3.7.7 | | | | |
| | 2000 NEW<br>Door openings in smoke barriers are installed as swinging or horizontal doors shall provide a minimum clear width as follows:<br>Provider Type / Swinging Doors / Horizontal Sliding Doors<br>Hospitals and Nursing Facilities: 41.5 inches (105 cm) / 83 inches (211 cm)<br>Psychiatric Hospitals and Limited Care Facilities: 32 inches (81 cm) / 64 inches (163 cm)<br>18.3.7.7 | ○ | ○ | ○ | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| K104 | 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** | | | | |
| K29 | 2000 EXISTING<br>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. 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 | | | |

*Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.*

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | 2000 NEW<br>Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a ¾ 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 |
|---|---|---|---|
| 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 | ✔ | ✔ | |
| 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 not considered hazardous, have separate protected storage and that are completely sprinkled. Gift shops may be open to the corridor 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 | | | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| K211 | Where Alcohol Based Hand Rub (ABHR) dispensers are installed:<br>☑ The corridor is at least 6 feet wide<br>☑ The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)<br>☑ The dispensers shall have a minimum spacing of 4 ft from each other<br>☑ Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.<br>☑ Dispensers are not installed over or adjacent to an ignition source.<br>☑ If the floor is carpeted, the building is fully sprinklered.<br>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<br>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<br>*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.* | | | | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | 2000 NEW<br>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.<br>• Room door to exit ≤ 100 ft (≤ 150 ft sprinklered)<br>• Point in room or suite to exit ≤ 150 ft (≤ 200 ft sprinklered)<br>• Point in room to room door ≤ 50 ft<br>• Point in suite to suite door ≤ 100 ft<br>18.2.6, 19.2.6 | ○ | ○ | | |
| K37 | 2000 EXISTING<br>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<br>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<br>Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3 | | | | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | 2000 NEW<br>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<br>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<br>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<br>*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.<br>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*<br>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<br>(Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) | ○ | ○ | ○ | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| 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)<br>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** | | | | |
| 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 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)<br>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 | | | | |
| | | | | | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | 2000 NEW (NURSING HOME AND EXISTING LIMITED CARE FACILITIES)<br>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)<br>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<br>Smoke Detection System<br>☐ Corridors<br>☐ Rooms<br>☐ Bath | | | | |
| 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<br>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<br>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 PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | 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 | | | | |
| K60 | 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** | | | | |
| K56 | 2000 EXISTING<br>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<br>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. | ○ | ○ | ○ | |
| K154 | 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. 04/17/2013 | | | | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | B. Show who provided the service. Summitt Fire Protection | | | | |
| | C. Note the source of water supply for the automatic sprinkler system. City Water Supply | | | | |
| | *(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)<br>(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 international symbol for no smoking.<br>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) | ○ | ○ | ○ | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | (2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision.<br>(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.<br>(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. | | | | K67<br>Based on observations and an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation..<br><br>Findings include:<br><br>During the facility tour between 9:00 AM and 12:00 PM on 04/16/14, an interview with the Facility Administrator (DC), a review of documentation and observations revealed that the HVAC systems for all wings of the 1963 and 1977 additions have ducted air supply to the corridors and no return or exhaust from the corridors. There is no supply or return in the resident rooms, which all have bathroom exhaust fans that are constantly exhausting to the outside. This situation is using the corridors as a supply plenum.<br><br>This was confirmed by the Director of Environmental Services (TM)<br><br>An annual waiver has been previously granted. |
| | **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.<br>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.<br>18.5.2.2, 19.5.2.2. | | | | |
| K69 | Cooking facilities shall be protected in accordance with 9.2.3.<br>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).<br>18.7.8, 19.7.8 | | | | |
| K71 | Rubbish Chutes, Incinerators and Laundry Chutes.<br>18.5.4, 19.5.4, 9.5, 8.4, NFPA 82<br>(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.<br>(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.<br>(3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. | | | | |

| ID 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<br>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.<br>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<br>(Includes firefighters service **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) | | | | |
| | 2000 NEW<br>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.<br>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<br>(Includes firefighters service **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) | ○ | ○ | ○ | |
| K161 | 2000 EXISTING<br>Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.<br>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 | | | | |

| 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<br>Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.<br>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** | | | | |
| K73 | 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 | ○ | ○ | ○ | |
| K74 | 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<br>☐ 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.<br>☐ 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<br>☐ Newly introduced upholstered furniture and mattresses means purchased since March, 2003. | ○ | ○ | ○ | |
| K75 | 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/ft$^2$ (20.4 L/m$^2$). A | ○ | ○ | ○ | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | capacity of 32 gal (121 L) shall not be exceeded within any 64-ft$^2$ (5.9-m$^2$) 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 | ○ | ○ | ○ | |
| | **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 PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| | 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 | Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.<br>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.<br>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside.<br>4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 | ○ | ○ | ○ | |
| K77 | Piped in medical gas, vacuum and waste anesthetic gas disposal systems comply with NFPA 99, Chapter 4. | ○ | ○ | ○ | |
| K78 | Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.<br>(a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others.<br>(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 | ○ | ○ | ○ | |
| K140 | Medical gas warning systems shall be in accordance with NFPA 99, Standard for Health Care Facilities.<br>(a) Master alarm panels are in two separate locations and have audible and visible signals.<br>(b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4-3.1.2.2<br>(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.<br>4-3.1.2.2 (NFPA 99) | ○ | ○ | ○ | |
| 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:<br>CAUSION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99) | ○ | ○ | ○ | |

| ID PREFIX | | MET | NOT MET | N/A | REMARKS |
|---|---|---|---|---|---|
| K142 | All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19. | ○ | ○ | ○ | |
| K143 | Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows::<br>(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<br>(b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and<br>(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.<br>8-6.2.5.2 (NFPA 99) | ○ | ○ | ○ | |
| | **ELECTRICAL AND EMERGENCY POWER** | | | | |
| K106 | 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) | ○ | ○ | ○ | |
| K107 | Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72.<br>9.6.1.4, 18.3.4.1, 19.3.4.1 | ○ | ○ | | |
| K108 | 2000 NEW (INDICATE N/A FOR EXISTING)<br>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 | ◉ | ○ | ○ | |
| K144 | Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110.<br>3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) | ○ | ○ | ○ | |
| K145 | 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 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<br>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 | Office | Date |
|---|---|---|---|
| Fire Authority Official *(Signature)* | Title | Office | Date |

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

| PROVIDER NUMBER | FACILITY NAME | SURVEY DATE |
|---|---|---|
| K1 245465 | **COMMUNITY MEMORIAL HOME** | *K4 **04/16/2014** |

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 2

NUMBER OF THIS BUILDING 01

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

| Health Care Form | | |
|---|---|---|
| 12 | 2786 R | 2000 EXISTING |
| 13 | 2786 R | 2000 NEW |

| ASC Form | | |
|---|---|---|
| 14 | 2786 U | 2000 EXISTING |
| 15 | 2786 U | 2000 NEW |

| ICF/MR Form | | |
|---|---|---|
| 16 | 2786 V, W, X | 2000 EXISTING |
| 17 | 2786 V, W, X | 2000 NEW |

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

*(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)*

K29: [ ] K56: [ ]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

| A1 | A2 | A3 | A4 | A5 |
|---|---|---|---|---|
| [ ] | [X] | [ ] | [ ] | [ ] |
| (COMP. WITH ALL PROVISIONS) | (ACCEPTABLE POC) | (WAIVERS) | (FSES) | (PERFORMANCE BASED DESIGN) |

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

| A. | B. | C. |
|---|---|---|
| [X] | [ ] | [ ] |
| FULLY SPRINKLERED (All required areas are sprinklered) | PARTIALLY SPRINKLERED (Not all required areas are sprinklered) | NONE (No sprinkler system) |

*MANDATORY

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

| PROVIDER NUMBER | FACILITY NAME | SURVEY DATE |
|---|---|---|
| K1 245465 | **COMMUNITY MEMORIAL HOME** | *K4 **04/16/2014** |

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 2

NUMBER OF THIS BUILDING 02

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

| Health Care Form | | |
|---|---|---|
| 12 | 2786 R | 2000 EXISTING |
| 13 | 2786 R | 2000 NEW |

| ASC Form | | |
|---|---|---|
| 14 | 2786 U | 2000 EXISTING |
| 15 | 2786 U | 2000 NEW |

| ICF/MR Form | | |
|---|---|---|
| 16 | 2786 V, W, X | 2000 EXISTING |
| 17 | 2786 V, W, X | 2000 NEW |

*K7 [13] SELECT NUMBER OF FORM USED FROM ABOVE

*(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)*

K29: [ ] K56: [ ]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

| A1 [X] | A2 [ ] | A3 [ ] | A4 [ ] | A5 [ ] |
|---|---|---|---|---|
| (COMP. WITH ALL PROVISIONS) | (ACCEPTABLE POC) | (WAIVERS) | (FSES) | (PERFORMANCE BASED DESIGN) |

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

| A. [X] | B. [ ] | C. [ ] |
|---|---|---|
| FULLY SPRINKLERED (All required areas are sprinklered) | PARTIALLY SPRINKLERED (Not all required areas are sprinklered) | NONE (No sprinkler system) |

*MANDATORY

**ORIGINAL**

**For Fire Marshal Division File**

02/27/2013 JAA

04/16/2014 JAA

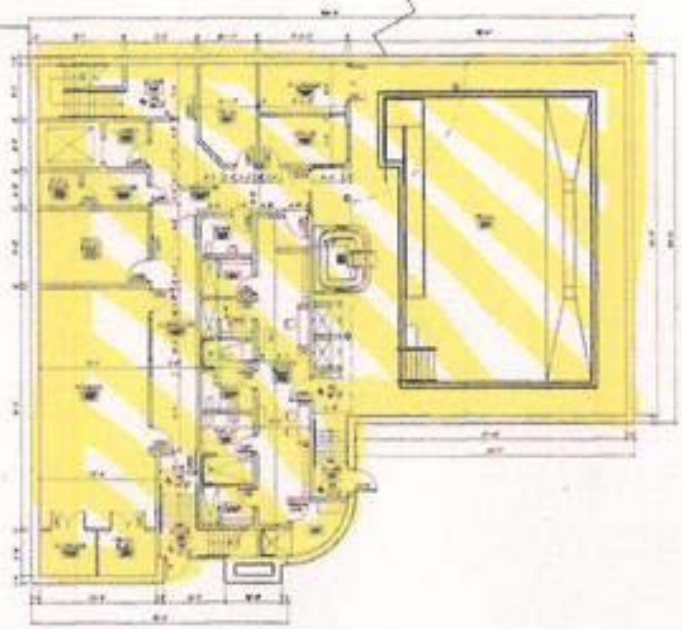
0014-0179 North ↑


Community Memorial Home
Galeon
410 West Main Street
Osakis, MN 56360

PT / OT Wellness Center Built 2008 of Type-II (111) Construction

0179

ORIGINAL
For Fire Marshal Division File
02/27/2013 JAA
04/16/2014 JAA



SGN

Galeon
Osakis, Minnesota

ADDITION & REMODELING

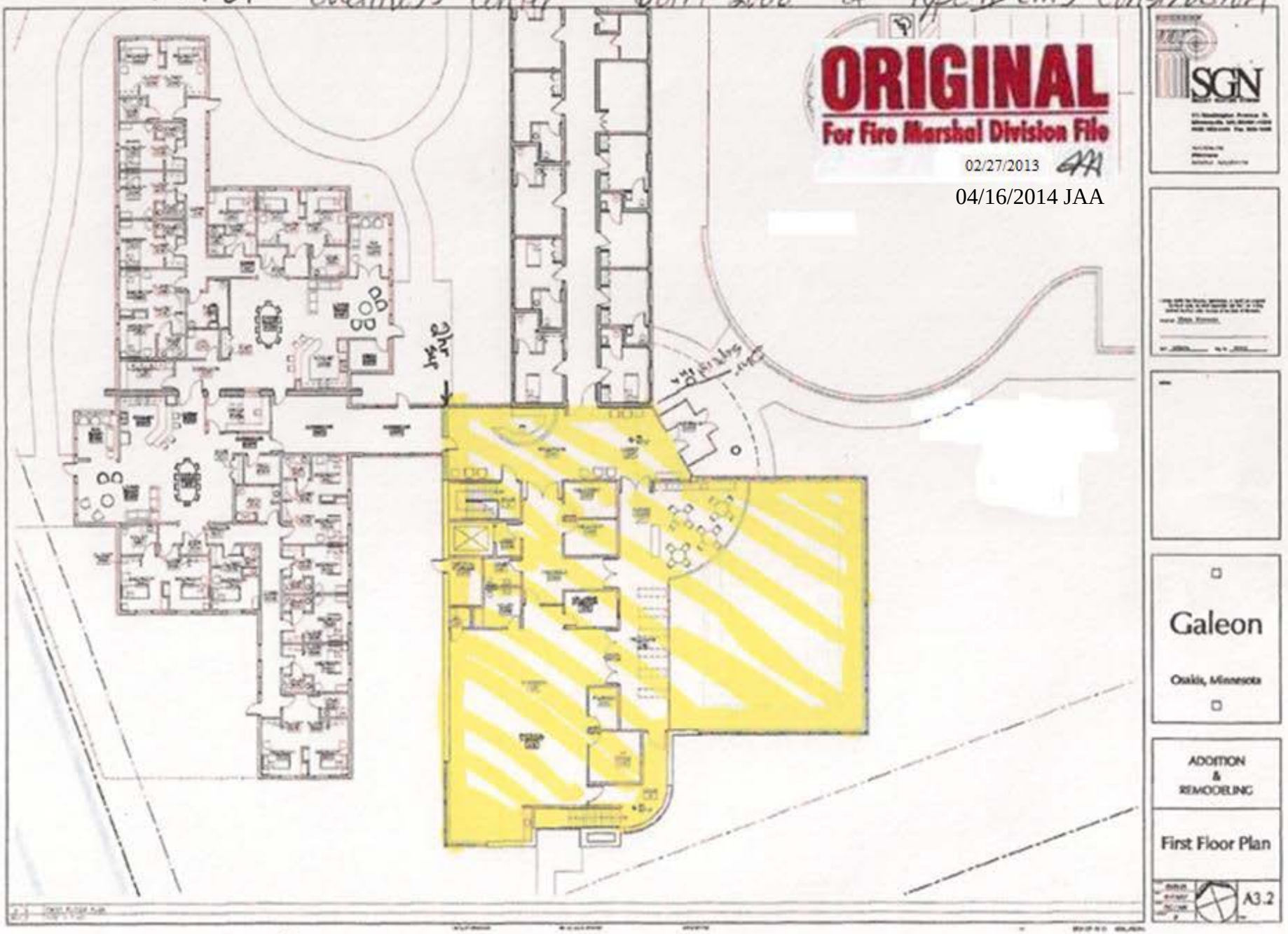
Lower Level

A3.1

Community Memorial Home - OSAKIS

PT/OT Wellness Center Built 2008 of Type II (111) Construction

0179




Community Memorial Home - OSAKIS

| PROJECT NUMBER: | PROVIDER NAME | SURVEY DATE |
|---|---|---|
| F5465023 | Community Memorial Home - Osakis | 04/16/2014 |

Administrator: Dave Carlson | Phone Number: 320-859-2142

Email address: dcarlson@galeonmn.com

State Fire Inspector: James A. Anderson, M.S.

**These are preliminary findings only. A complete and final Statement of Deficiencies 2567 report will be provided by US Mail.**

☐ **At the time of this inspection, this facility was found to comply with the requirements of the 2000 Life Safety Code applicable to: ☐ SNF/NF ☐ Hospital ☐ ICFMR ☐ ASC Facilities participating in the Medicare/Medicaid programs.**

☑ **The following fire/life safety deficiencies were found during this inspection:**

| K TAG S& S | ☑ **Draft Summary of Deficiency(ies)** ☐ **Revisit** ☐ **Clearance** |
|---|---|
| K67 SS=F | During the facility tour an interview with the Assistant Director of Environmental Services (TM), a review of documentation and observations revealed that the HVAC systems for all wings of the 1963 and 1977 additions have ducted air supply to the corridors and no return or exhaust from the corridors. There is no supply or return in the resident rooms, which all have bathroom exhaust fans that are constantly exhausting to the outside. This situation is using the corridors as a supply plenum.<br><br>This was confirmed by the Director of Environmental Services (TM).<br><br>An annual waiver has been previously granted. |

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
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 Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

**Name of Facility**

Community Memorial Home (CMH) at Osakis, MN Inc.

**2000 CODE**

**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<br>K067<br><br>Heating, Ventilation and Air Conditioning (HVAC) equipment at CMH does not comply with LSC (00) Section 9.2 and NFPA 90A, 1999 Edition because the corridors are used as a plenum. | A continuing waiver is being requested for K067 for the following reasons:<br>A. An extreme financial hardship on Community Memorial Home(CMH) will result from compliance because:<br>1. Revised estimates (5-14-14, attached) show that compliance with NFPA 90A will cost between $446,120 and $579,299. These dollars are not available under current reimbursement rules;<br>2. The electrical system at CMH would need to be modified at a cost that may exceed $42,000;<br>3. Asbestos abatement during installation would cost between $59,483 and $81,900; and<br>4. Non-complying systems are allowed to be used under LSC(00), 9.2.1.<br>B. If this waiver is approved, the safety of building occupants will not be compromised because:<br>1. CMH was built under Type II construction standards;<br>2. Walls, floors, ceilings and vertical openings at CMH already resist the passage of smoke;<br>3. CMH is completely protected by a supervised sprinkler system installed in accordance with NFPA 13;<br>4. HVAC ventilation fans automatically shut down upon activation of a fire alarm or upon detection of smoke;<br>5. Resident sleeping rooms are all equipped with single station battery operated smoke detectors;<br>6. The property of CMH is smoke and tobacco free with signs posted to that effect;<br>7. All CMH Corridors are equipped with a compliant UL listed smoke detection system;<br>8. The local fire department is located 6 blocks away and can respond to an alarm in less than 10 mins.;<br>9. CMH has an approved fire safety plan and is compliant with all other fire safety requirements; and<br>10. A continuing waiver has been approved annually in the past for Community Memorial.<br><br>Requested by: David E. Carlson Administrator 5-14-2014<br>David E. Carlson, Administrator 5-14-2014 |

| Surveyor *(Signature)* | Title | Office | Date |
|---|---|---|---|
| Fire Authority Official *(Signature)* | Title Fire Safety Supervisor | Office State Fire Marshal | Date 5-23-14 |


3315 Roosevelt Road, Ste. 100
St. Cloud MN 56301
Bus. (320) 251-0262 Fax: (320) 251-5749

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

| | | Low Range 24,000 S.F. | | High Range 24,000 S.F. | |
|---|---|---|---|---|---|
| | | DOLLARS | | DOLLARS | |
| ***I. LAND*** | ***SUBTOTAL LAND*** | $ - | | $ - | |
| ***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 | | $ 5,305 | $ 0.22 | $ 10,816 | $ 0.45 |
| ELECTRICAL | | $ 37,132 | $ 1.55 | $ 43,264 | $ 1.80 |
| CONTINGENCY | | $ 30,000 | $ 1.25 | $ 38,000 | $ 1.58 |
| | ***SUBTOTAL CONSTRUCTION COSTS*** | $ 321,748 | $ 13.41 | $ 413,315 | $ 17.22 |
| ***III. SOFT COSTS*** | | | | | |
| FEES / PERMITS / PRINTING | | $ 64,890 | $ 2.70 | $ 84,084 | $ 3.50 |
| OTHER | | $ - | $ - | $ - | $ - |
| | ***SUBTOTAL SOFT COSTS*** | $ 64,890 | $ 2.70 | $ 84,084 | $ 3.50 |
| ***IV. OWNER ITEMS*** | | | | | |
| FURNITURE/FIXTURES/EQUIPMENT | | $ - | | $ - | |
| OTHER - ASBESTOS ABATEMENT | | $ 59,483 | $ 2.48 | $ 81,900 | $ 3.41 |
| | ***SUBTOTAL OWNER ITEMS COSTS*** | $ 59,483 | $ 2.48 | $ 81,900 | $ 3.41 |
| ***V. TOTAL PROJECT COST*** | | $ 446,120 | $ 18.59 | $ 579,299 | $ 24.14 |