

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 60L1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00129

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245083		3. NAME AND ADDRESS OF FACILITY (L3) PARK HEALTH AND REHABILITATION CENTER (L4) 4415 WEST 36 1/2 STREET (L5) SAINT LOUIS PARK, MN (L6) 55416		4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2.STATE VENDOR OR MEDICAID NO. (L2) 046342600		5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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	
6. DATE OF SURVEY 04/01/2013 (L34)		8. ACCREDITATION STATUS: <u> </u> (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		FISCAL YEAR ENDING DATE: (L35) 12/31	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements <u> </u> 2. Technical Personnel <u> </u> 6. Scope of Services Limit Compliance Based On: <u> </u> 3. 24 Hour RN <u> </u> 7. Medical Director <u> </u> 1. Acceptable POC <u> </u> 4. 7-Day RN (Rural SNF) <u> </u> 8. Patient Room Size X 5. Life Safety Code <u> </u> 9. Beds/Room			
12.Total Facility Beds 81 (L18)		B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A,5 (L12)			
13.Total Certified Beds 81 (L17)					
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 81 (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 <u>Gloria Derfus, Unit Supervisor</u> (L19)		Date : 04/10/2013	18. STATE SURVEY AGENCY APPROVAL <u>Shellae Dietrich, Program Specialist</u> (L20)		Date: 04/11/2013
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Participate <u> </u> 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 : <u> </u>	
22. ORIGINAL DATE OF PARTICIPATION 02/01/1979 (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) <u>VOLUNTARY</u> 00 <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 00450 (L28) (L31)		30. REMARKS Posted 4/24/2013 ML	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE 01/17/2013 (L33)		DETERMINATION APPROVAL	

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 60L1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00129

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN# 24-5083

A standard OTC survey was completed at this facility on December 24, 2012. The most serious deficiencies were cited at a S/S level of D. In addition on January 16, 2013, a Federal Monitoring Survey was completed and deficiencies were found, the most serious at a S/S level of F. On January 30, 2013, the CMS RO notified the facility of the following:

- Mandatory DOPNA, effective March 20, 2013
- A loss of NATCEP for a two year period beginning March 20, 2013 if DOPNA were to go into effect

A PCR of the health deficiencies was completed on February 4, 2013. A PCR of the FMS deficiencies was completed on April 1, 2013. All of the deficiencies were found corrected. The facility was found in compliance as of March 19, 2013. As a result, we recommended the following action to the CMS RO and CMS concurred:

- Mandatory DOPNA, effective March 20, 2013, be rescinded.

This would also mean that the facility would not be subject to a loss of NATCEP.

The facility's request for a continuing waiver involving the deficiency cited at K67 is recommended for approval. The facility's request for a temporary waiver involving the deficiency cited at K144 with a completion date of June 15, 2013 is also recommended for approval. Documentation supporting the waiver request is attached.

See the attached CMS-2567B forms for the February 4, 2013 and April 1, 2013 revisit.



Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5083

April 11, 2013

Ms. Kristie Johnsrud, Administrator
Park Health and Rehabilitation Center
4415 West 36 1/2 Street
Saint Louis Park, Minnesota 55416

Dear Ms. Johnsrud:

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 March 19, 2013 the above facility is certified for:

81 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 81 skilled nursing facility beds.

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K67.

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

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

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

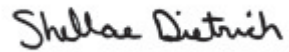
Park Health And Rehabilitation Center

April 11, 2013

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Please contact me if you have any questions.

Sincerely,

A handwritten signature in cursive script that reads "Shellae Dietrich".

Shellae Dietrich, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Division of Compliance Monitoring

Minnesota Department of Health

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone #: (651) 201-4109 Fax #: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

April 10, 2013

Ms. Kristie Johnsrud, Administrator
Park Health and Rehabilitation Center
4415 West 36 1/2 Street
Saint Louis Park, Minnesota 55416

RE: Project Number S5083023

Dear Ms. Johnsrud:

On January 4, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 24, 2012. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

In addition, on January 16, 2013, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As you were informed during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On January 30, 2013, CMS forwarded the results of the FMS to you and informed you that the following remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 20, 2013

Also, the CMS Region V Office notified you in their letter of January 30, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), if your facility failed to achieve substantial compliance by March 20, 2013, your facility would be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 20, 2013.

On February 4, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 1, 2013 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 24, 2012 and

April 10, 2013

Page 2

the FMS completed on January 16, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 19, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 24, 2012 and the FMS survey completed on January 16, 2013, effective March 19, 2013. As a result of the PCR findings, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in the letter to you dated January 30, 2013, will not be imposed. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 20, 2013, be rescinded.

In the CMS letter of January 30, 2013, you were advised that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility would be prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 20, 2013, if denial of payment for new admissions should go into effect. Since your facility attained substantial compliance on March 19, 2013, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Correction of the Life Safety Code deficiency cited under K144 at the time of the January 16, 2013 FMS, has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of June 15, 2013, has been forwarded to the Region V Office of the Centers for Medicare and Medicaid Services (CMS) for their review and determination. Failure to come into substantial compliance with these deficiencies by the date indicated in your plan of correction may result in the imposition of enforcement remedies. Your request for a continuing waiver involving the deficiency cited under K67 at the time of the January 16, 2013 FMS has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

5083r113.rtf

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245083	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 2/4/2013
Name of Facility PARK HEALTH AND REHABILITATION CENTER		Street Address, City, State, Zip Code 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

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 F0329 Reg. # 483.25(I) LSC _____	Correction Completed 02/01/2013	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By _____ GD/sd	Date: _____ 04/10/13	Signature of Surveyor: _____ 18623	Date: _____ 02/04/13
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Followup to Survey Completed on: 12/20/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519



CMS Certification Number (CCN): 245083

January 30, 2013
(By Certified Mail and Facsimile)

Ms. Kristie Johnsrud, Administrator
Park Health and Rehabilitation Center
4415 West 36 1/2 Street
Saint Louis Park, MN 55416

Dear Ms. Johnsrud:

**SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND
NOTICE OF IMPOSITION OF REMEDY
Cycle Start Date: December 20, 2012**

STATE SURVEY RESULTS

On December 20, 2012, a health survey and complaint investigations and on December 24, 2012, a Life Safety Code (LSC) survey were completed at Park Health and Rehabilitation Center by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiency at Scope and Severity (S/S) level D, cited as follows:

- F329 -- S/S: D -- 483.25(l) -- Drug Regimen is Free From Unnecessary Drugs

The MDH advised you of the deficiency that led to this determination and provided you with a copy of the survey report (CMS-2567).

FEDERAL MONITORING SURVEY

In its notice dated January 4, 2013, the MDH informed you that your facility could avoid the imposition of remedies if substantial compliance was achieved by February 2, 2013. However, a surveyor representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility on January 16, 2013. As the surveyor informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found additional deficiencies, with the most serious being at S/S level F, cited as follows:

- K48 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K51 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K54 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

- K67 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K144 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K146 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K154 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

The findings from the FMS are enclosed with this letter on form CMS-2567.

PLAN OF CORRECTION

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (POC) for the enclosed deficiencies cited at the FMS. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- How the facility will identify other residents having the potential to be affected by the same deficient practice;
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur;
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Send your POC to the following address:

Bruce Wexelberg, Safety Engineer
Centers for Medicare & Medicaid Services
Division of Survey and Certification
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

INFORMAL DISPUTE RESOLUTION

The MDH offered you an opportunity for informal dispute resolution (IDR) following its survey visit. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an informal dispute resolution (IDR) process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR 488.331. To use this process, you must send your written request, identifying the specific deficiencies you are disputing, to Heather A. Lang, Branch Manager, at the Chicago address shown above. The request must set forth in detail your reasons for disputing each deficiency and include copies of all relevant documents supporting your position. A request

for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your POC. You must provide an acceptable POC for all cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

LIFE SAFETY CODE (LSC) WAIVERS

If you request an annual waiver for a LSC deficiency cited during the FMS, the request must indicate why correcting would impose an unreasonable hardship on the facility; if high cost is the hardship, you must include recent, bona fide cost estimates. In addition, the request must indicate how continued non-correction of the deficiency will not pose a risk to resident safety, based on additional compensating features or other reasons.

Each cited deficiency (other than those which receive annual waivers) must be corrected within a reasonable timeframe. If a reasonable correction date falls beyond your enforcement cycle's three month date, you may request a temporary waiver to allow correction by the reasonable date, and without the noncompliance leading to the imposition of remedies. Include a request for a temporary waiver as part of your POC, indicating the basis for the length of correction time needed, and include a timetable for correction. A temporary waiver may be granted if the POC date extends beyond your enforcement cycle's three month date, and if the correction timeframe is reasonable, in CMS' judgment. Your enforcement cycle's three month date is March 20, 2013.

SUMMARY OF ENFORCEMENT REMEDIES

As a result of the survey findings, we are imposing the following remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 20, 2013

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

DENIAL OF PAYMENT FOR NEW ADMISSIONS

Mandatory denial of payment for all new Medicare admissions is imposed effective March 20, 2013 if your facility does not achieve compliance within the required three months. This action is mandated by the Social Security Act at Sections 1819(h)(2)(D) and 1919 (h)(2)(C) and Federal

regulations at 42 CFR Section 488.417(b). We are notifying National Government Services that the denial of payment for all new Medicare admissions is effective on March 20, 2013. We are further notifying the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective March 20, 2013.

You should notify all Medicare and Medicaid residents admitted on or after this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

TERMINATION PROVISION

If your facility has not attained substantial compliance by June 20, 2013, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Social Security Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR Section 489.57 will apply.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$5,000.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 20, 2013, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Park Health and Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 30, 2013. You will receive further information regarding this from the MDH. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the MDH and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS

This formal notice imposed the following remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 20, 2013

If you disagree with the finding of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 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 notice.** Such a request should be made to:

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, D.C. 20201

It is important that you send a copy of your request to our Chicago office to the attention of Tamika J. Brown. Failure to do so could result in our office proceeding with collection of the CMP.

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. 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 DAB will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing. Counsel may represent you at a hearing at your own expense.

REQUIRED SPRINKLER STATUS BY AUGUST 13, 2013

On August 13, 2008, CMS published a final rule that requires all long-term care facilities to be equipped with a complete supervised automatic sprinkler system by no later than August 13, 2013. Facilities with no or partial sprinkler systems installed and/or that use waivers or the Fire Safety Evaluation System (FSES) to comply with the current sprinkler requirements have until August 13, 2013 to install or upgrade the sprinkler system. Please review your facility's sprinkler system to ensure it fully complies with the National Fire Protection Association's (NFPA) "Standard for the Installation of Sprinkler Systems" (1999 Edition, NFPA 13). The Federal survey process requires review of the sprinkler system to determine if the system is providing complete coverage or only partial coverage. Complete coverage means that the entire facility, including all closets, storage areas and walk-in coolers and freezers are sprinkler protected. There are specific requirements for overhangs attached to the outside of the building (1999 Edition, NFPA 13, Section 5-13.8), electrical equipment rooms (1999 Edition, NFPA 13,

Section 5-13.11) and Elevator Hoistways and Machine Rooms (1999 Edition, NFPA 13, Section 5-13.6) that are the responsibility of the facility to understand and comply with, that may result in costly upgrades that will require time to complete. **Since there is no waiver and/or FSES provision after August 13, 2013, it is imperative that you ensure that your facility is fully sprinkled in accordance with the regulation on August 13, 2013. Failure to do so is likely to result in enforcement remedies, including but not limited to termination.**

CONTACT INFORMATION

For questions regarding this enforcement case, please contact Tamika J. Brown, Program Representative, at (312) 353-1502 or Mrs. Charlotte A. Hodder, RN, BSN, CRRN, Certification Specialist, at (312) 353-5169. Information may also be faxed to (443) 380-6614. All correspondence should be directed to Tamika J. Brown in our Chicago office.

Sincerely,

/s/

Heather A. Lang
Branch Manager
Long Term Care Certification
& Enforcement Branch

Enclosure: Statement of Deficiencies (CMS-2567)

cc: Minnesota Department of Health
Minnesota Department of Human Services
National Government Services
Office of Ombudsman for Older Minnesotans
Stratis Health
Office of the US Attorney, District of Minnesota

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245083	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN BUILDING 01	(Y3) Date of Revisit 4/1/2013
Name of Facility PARK HEALTH AND REHABILITATION CENTER		Street Address, City, State, Zip Code 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416

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 _____ Reg. # NFPA 101 LSC K0014	Correction Completed 03/19/2013	ID Prefix _____ Reg. # NFPA 101 LSC K0018	Correction Completed 03/19/2013	ID Prefix _____ Reg. # NFPA 101 LSC K0020	Correction Completed 03/19/2013
ID Prefix _____ Reg. # NFPA 101 LSC K0033	Correction Completed 03/19/2013	ID Prefix _____ Reg. # NFPA 101 LSC K0038	Correction Completed 03/19/2013	ID Prefix _____ Reg. # NFPA 101 LSC K0048	Correction Completed 03/19/2013
ID Prefix _____ Reg. # NFPA 101 LSC K0050	Correction Completed 03/19/2013	ID Prefix _____ Reg. # NFPA 101 LSC K0051	Correction Completed 03/19/2013	ID Prefix _____ Reg. # NFPA 101 LSC K0052	Correction Completed 03/19/2013
ID Prefix _____ Reg. # NFPA 101 LSC K0054	Correction Completed 03/19/2013	ID Prefix _____ Reg. # NFPA 101 LSC K0056	Correction Completed 03/19/2013	ID Prefix _____ Reg. # NFPA 101 LSC K0062	Correction Completed 03/19/2013
ID Prefix _____ Reg. # NFPA 101 LSC K0143	Correction Completed 03/19/2013	ID Prefix _____ Reg. # NFPA 101 LSC K0146	Correction Completed 03/19/2013	ID Prefix _____ Reg. # NFPA 101 LSC K0154	Correction Completed 03/19/2013

Reviewed By _____ State Agency	Reviewed By PS/sd	Date: 04/10/13	Signature of Surveyor: 28120	Date: 04/01/13
Reviewed By _____ CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/16/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

Loveland, Jim (MDH)

From: Suzuki, Jan M. (CMS/CQISCO) <Jan.Suzuki@cms.hhs.gov>
Sent: Wednesday, March 27, 2013 2:55 PM
To: Absolon, Mary (MDH)
Cc: Loveland, Jim (MDH)
Subject: Acceptable POC for Park Health and Rehab Ctr, #245083
Attachments: Scanned_document_16-01-2005_21-42-54.pdf

Mary,

We have an acceptable POC (see attachment) for the LSC FMS deficiencies found at the subject facility. We approved the Annual Waiver at K67 and a Temporary Waiver at K144 through 6/15/13.

Please conduct a revisit to determine compliance. Thanks.

Jan Suzuki
Principal Program Representative
Centers for Medicare & Medicaid Services
RO V, Chicago
Division of Survey and Certification
LTC Certification and Enforcement Branch
(P) 312-886-5209
(F) 443-380-6602
jan.suzuki@cms.hhs.gov

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Number of Pages:

CCN: 245083

DPNA Date: 03/20/2013

Name: Park Health and Rehabilitation Center

Termination Date: 06/20/2013

City, State: Saint Louis Park, MN

FMS Survey Date: 01/16/2013

Fed Surveyor: BWW

Contr Surveyor:

POC Date or Temporary Waiver

("TW") Date or Waiver ("AW")

[illegible]

Approved: **YES**

By: Bruce W. Wexelberg

Date: 03/26/2013

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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 38 1/2 STREET SAINT LOUIS PARK, MN 55416		
(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 A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 1/16/13 following a Minnesota Department of Health Survey on 12/24/12. At this Comparative Federal Monitoring Survey, Park Health and Rehabilitation Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101 - 2000 edition. Park Health and Rehabilitation Center is a two story building that was built at three different times. The original building was constructed in 1965 and is of Type II (111) construction. In 1972 an addition of Type II (000) construction was built. In 1995 a Physical Therapy addition of Type II (111) construction was built. The building is fully sprinklered and there is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. Because the building is fully sprinklered and Type II (000) construction is an acceptable type of construction for an existing two story healthcare occupancy the building was surveyed as one building of Type II (000) construction. The facility has 81 certified beds. All 81 beds are dually certified for Medicare and Medicaid. At the time of the survey the census was 78. The requirement at 42 CFR, subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD	K 000	Park Health and Rehab Center submits this plan of correction because it is required by State and Federal Regulation and is not a legal admission that this statement of deficiencies is correctly cited, and is not to be construed as an admission against the interest by the Center, the Administrator or any employees, agents or other individuals who draft or may be discussed in the response and plan of correction. Park Health and Rehabilitation respectfully submits this plan of correction and our allegation of compliance as of <u>March 19, 2013.</u>	3/1/13	
K 014 68-E		K 014			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 60 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

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OMB NO. 0938-0991

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416		
(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 014	Continued From page 1 Interior finish for corridors and 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. 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide interior finish materials that meet the flame spread requirements of NFPA 101 - 2000 edition, Sections 19.3.3.1, 19.3.3.2 and 10.2.3. This deficient practice could affect approximately 30 of the 76 residents. Findings include: 1. On 1/16/13 at 3:16pm, observation revealed that throughout the lower level carpet type wall covering was installed on the lower 31 inches of the corridor wall. The facility had no interior finish flame spread information on the carpet type wall covering. When asked at the time of the discovery if he knew what the flame spread rating of the carpet type wallcovering was the Maintenance Director replied, "No, I don't." 2. On 1/16/13 at 3:27pm, observation revealed that in the ice vending machine area that was open to the corridor there was wood paneling on two walls. The facility had no interior finish flame spread information on the wood paneling. When asked at the time of the discovery if he knew what the flame spread rating of the wood paneling was, the Maintenance Director said, "No, I don't."	K 014	K-14: 1. Carpet from lower level hallways will be removed. The plaster walls will be repaired and painted. The wood paneling in the ice vending machine area will be removed. It will be replaced with drywall using steel studs by March 19th, 2013. 2. The center will audit all walls for any similar paneling and remove it by March 19th, 2013. The center is unaware of any items that we do not have flame ratings for. 3. Upon new purchases Maintenance Director will ensure flame ratings are available. 4. Education will be conducted with Maintenance Director on obtaining flame rating for new purchase. 5. Audits will be conducted by Maintenance Director or designee to check for flame rating on new purchases. 6. Results will be brought to QPI by NHA or designee.	3/19/13	
K 018	NFPA 101 LIFE SAFETY CODE STANDARD	K 018			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DOWJ21

Facility ID: 00120

If continuation sheet Page 2 of 20

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

PRINTED: 01/25/2013
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OMB NO. 0938-0891

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4416 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416		
(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 01B SS=E	Continued From page 2 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide corridor doors that meet the requirements of NFPA 101 - 2000 edition, Sections 19.3.6.3, 19.3.6.3.1 and 19.3.6.3.2. This deficient practice could affect approximately 20 of the 76 residents. Findings include: On 1/16/13 at 3:02pm, observation revealed that there was a 1" hole in the corridor door to the northwest nursing office.	K 01B	K-18 1. The door to the northwest nursing office was repaired on 1/24/13. A deadbolt blank was fitted to the hole to bring it back to the 20 minute rating. 2. Maintenance Director checked other corridor doors to ensure no other openings of the same type existed on 1/24/13 and repaired if needed. 3. Maintenance Director will be educated that corridor openings in doors are prohibited and must be able to resist fire for at least 20 minutes. 4. Audits will be conducted by the Director of Maintenance or designee on corridor doors to ensure there are not any holes. 5. Results will be brought to QPI for further review by NHA or designee.	3/19/13	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DOWJ21

Facility ID: 00120

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4416 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416		
(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 018	Continued From page 3	K 018		3/19/13	
K 020 SS=E	This deficient practice was confirmed by the Facility Administrator and the Maintenance Director at the time of discovery. NFPA 101 LIFE SAFETY CODE STANDARD 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 8.2.6.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to maintain vertical opening protection as required by NFPA 101 - 2000 edition, section 19.3.1, 19.3.1.1, 8.2.3, 8.2.3.2.4 and 8.2.5, as well as NFPA 80A - 1999 section 3-4.7. This deficient practice could affect approximately 40 of the 76 residents. Finding include: On 1/16/13 at 1:48pm, observation revealed that by the reception area there was a 24" by 78" duct that penetrated the floor. The duct was not protected by a fire damper where it penetrated the floor. This deficient practice was confirmed by the Facility Administrator and the Maintenance Director at the time of discovery. NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire	K 020	K-20: 1. The 24" by 78" that penetrated the floor by the reception area was opened up and inspected. The ductwork did contain a fire damper. A contractor was brought in to verify and test the damper to make sure it was functional. Access panels are currently in place and are able to be removed for inspection when needed. Dampers will be visually inspected, cleaned and exercised annually. Date of compliance March 19th, 2013. 2. Other similar areas will be inspected to ensure fire dampers are present. 3.. Education will be completed with Maintenance Director on making sure that ducts are protected by a fire damper that is functioning by March 19th, 2013. 4. Audits will be conducted by Maintenance Director to ensure that all fire dampers are located, inspected and tested annually to remain in compliance.		
K 033 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire	K 033	5. Audits will be brought to QPI for review by NHA or designee.		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 56 1/2 STREET SAINT LOUIS PARK, MN 55416		
(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 033	Continued From page 4 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. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the vertical opening protection required by NFPA 101 - 2000 edition, Sections 19.3.1.1, 19.2.1, 19.2.2.3, 7.1.3.2, 7.2.2.5, 8.2.3, 8.2.3.1.1, 8.2.3.1.2, 8.2.3.2.1, 8.2.3.2.3.1, 8.2.5 and 8.2.5.2, 8.2.5.3 and 8.2.5.4. This deficient practice could affect approximately 40 of the 76 residents. Findings include: - On 1/16/13 at 2:01pm, observation revealed that the door to the stair by room 263 was not a fire rated door. - On 1/16/13 at 2:58pm, observation revealed that the door to the stair by room 221 was not a fire rated door. - On 1/16/13 at 3:26pm, observation revealed that the door from the janitors closet to the first floor northwest stair lacked a label indicating its fire resistance rating. - On 1/16/13 at 3:51pm, observation revealed that the door to the first floor southeast stair was not a fire rated door.	K 033	K-33: - The door to the stair by room 263 will be replaced with a door that has a fire rating of 90 minutes. The door to the stair by room 221 will be replaced with a door that has a fire rating of 90 minutes. The door to the janitor's closet in the North West stair will be removed. The contents of this room will be removed and this room will be made part of the stairway enclosure. Any modifications to this room to comply with making it a one hour enclosure will be done. The door to the first floor southeast stair will be replaced with a door with a fire rating of 90 minutes. The door to the first floor northwest stair will be replaced with a door with a fire rating of 90 minutes. - Other doors will be inspected by the Director of Maintenance to ensure fire ratings are present by March 19th, 2013. - Education will be completed with Maintenance Director on ensuring that any new doors installed have a fire resistance rating by March 19th, 2013. - Audits will be conducted by Director of Maintenance or designee to make sure that any new door that is installed has a fire resistance rating. - Results will be brought to QPI for further review by NHA or designee.	3/19/13	

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Event ID: DOW/J21

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 38 1/2 STREET SAINT LOUIS PARK, MN 55416		
(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 033	Continued From page 5 5. On 1/16/13 at 3:57pm, observation revealed that the door to the first floor northwest stair was not a fire rated door. These deficient practices were confirmed by the Facility Administrator and the Maintenance Director at the time of discovery. NFFA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide means of egress in accordance with the requirements of NFFA 101 - 2000 edition, Sections 19.2.1, 19.2.2, 7.2.1.5.4, 7.2.2, 7.1.3.2.1, 7.1.10.2 and 7.7.3. This deficient practice could affect approximately 40 of the 76 residents. Findings include: 1. On 1/16/13 at 1:55pm, observation revealed that the door knob hardware on the door to the stair by room 263 was located 70" above the floor. 2. On 1/16/13 at 2:02pm, observation revealed that on the second floor in the exit stair by room 263 a room with a sign that said "Heating Plant" opened directly onto the stair. The room contained a furnace that the Maintenance	K 033	K-38: 1. Door by room 263 will be replaced with a door with a fire rating of 90 minutes and with a proper door knob and hardware. The door to the room that was formerly called the "heating plant" will be removed. The contents of this room will be removed and the room will become part of the stair enclosure. Any modifications to this room to comply with making it a one hour enclosure will be done. The wheelchair was removed from the staircase on 1/16/13. The door to the stair by room 221 will be replaced with a door that has a 90 minute fire rating and proper door knob and hardware will be installed. The janitors closet at the bottom of the northwest staircase will be removed. The contents of this room will be removed and this room will be made part of the stairway enclosure. This will be completed by March 19 th , 2013. 2. Education with staff on making sure exits are readily accessible at all times will be completed by March 19 th , 2013. 3. Audits will be conducted to ensure exit areas are accessible at all times by the Maintenance Director or designee.	3/19/13	
K 033 86=E		K 033			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DOW/J21

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4. Results will be brought monthly QPI meeting by NHA for further review.

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

PRINTED: 01/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 56 1/2 STREET SAINT LOUIS PARK, MN 55416		
(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 038	Continued From page 6 Director said was "abandoned" and not working. Rooms that are not normally occupied can not open directly onto the rated stair enclosure. 3. On 1/16/13 at 2:03pm, observation revealed that the door knob hardware on the door to the stair by room 221 was located 70" above the floor. 4. On 1/16/13 at 3:07pm, observation revealed that a wheel chair was stored under the Therapy stair on the first floor. The wheel chair was under the stair during the orientation tour at 9:45am and was in the same location at 3:07pm. 5. On 1/16/12 at 3:25pm, observation revealed that on the first floor of the northwest stair a janitors closet opened directly onto the rated stair enclosure. These deficient practices were confirmed by the Facility Administrator and the Maintenance Director at the time of discovery. NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have a written fire safety plan addressing all the items required by NFPA 101 - 2000 edition, Section 19.7.2.2. This deficient practice could affect all 76 residents.	K 038	K-48 1. Facilities written fire safety plan was corrected on 1/18/13, to include and identify the correct smoke compartments. 2. Staff will be educated on the 8 smoke compartments by March 19 th , 2013. 3. Maintenance Director will be educated on the correct number of smoke compartments by March 19 th , 2013. 4. Audits will be conducted on any physical layout that would require an updated emergency plan. 5. Results will be brought to QPI for review.	3/19/13	
K 049 88MF		K 048			

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Event ID: D01WJ21

Facility ID: 00123

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013	
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 4416 WEST 86 1/2 STREET SAINT LOUIS PARK, MN 55418			
(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 048	Continued From page 7 Findings Include: On 1/16/13 at 10:40am, review of the document titled "Park Health & Rehabilitation Center Fire Safety Plan" dated 12/21/09 revealed that the facility's written fire safety plan states that the facility has six smoke compartments. A review of the drawing titled "Park Health & Rehabilitation Center Emergency Evacuating Route, Upper Level and Garden Level" as well as a tour of the facility revealed that there are eight smoke compartments in the facility. If staff does not understand how the smoke compartments in the facility are arranged they may evacuate residents into an unsafe area of the facility in the event of a fire. This deficient practice was confirmed by the Facility Administrator and the Maintenance Director at the time of discovery. NFPA 101 LIFE SAFETY CODE STANDARD		K 048	K-50: 1. Fire drills completed for January were conducted at varied times. This was reviewed by the Administrator and Director of Maintenance on 2/6/13. 2. Maintenance staff will be educated in the importance of conducting these drills at unexpected times and varying conditions by March 19 th , 2013. 3. Administrator will review drill compliance each month. 4. Results will be brought QPI for further review by NHA or designee.		3/14/13	
K 050 SS-C	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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct fire drills in accordance with the		K 050				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DQWJ21

Facility ID: 00129

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248083	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416		
(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 050	Continued From page 8 requirements of NFPA 101 - 2000 edition, Section 19.7.1.2. This deficient practice could affect all 76 residents. Findings Included: On 1/16/13 at 11:10am, review of the documents titled "Fire Drill Report (Or Fire Report)" for the last 12 months revealed that fire drills were not conducted at varied times. On the second shift 10 fire drills were conducted over the last 12 months. All 10 of the fire drills were conducted between 3:24pm and 4:23pm. This deficient practice was confirmed by the Facility Administrator and the Maintenance Director at the time of discovery. NFPA 101 LIFE SAFETY CODE STANDARD	K 050	K-51: 1. Facility will replace existing fire panel with updated version and will add annunciator at the nurses station where it is staffed 24/7. This will be completed by March 19 th , 2013. 2. Maintenance Director will be educated on the requirement of a remote annunciator panel by March 19 th , 2013. 3. Audits will be conducted to make sure all zones are highlighted on remote fire panel by the Director of Maintenance or designee. 4. Results will be brought to QPI for review.	3/19/13	
K 051 SS=F	A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DOWJ21

Facility ID: 00120

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

FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 86 1/2 STREET SAINT LOUIS PARK, MN 55416		
(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 051	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install the fire alarm system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 1999 edition, Section 1-5.4.6. This deficient practice could affect all 76 residents. Findings include: On 1/16/13 at 1:32pm, observation revealed that there was no remote annunciator for the fire alarm panel at a location where an alarm was likely to be heard 24 hours a day. The main fire alarm panel was not located where an alarm could be heard 24 hours a day. There was a fire alarm zone annunciator located by the reception area. An interview with the Maintenance Director at the time of the observation revealed that the panel did not annunciate all of the items on the fire alarm panel and the reception desk was not staffed 24 hours a day.	K 051	K-52: 1. The fire alarm inspection contractor will do a complete assessment of all smoke detectors in the facility. An accurate count of detectors and the type of detector will be obtained. The fire alarm inspection contractor will then do an inspection of the entire system including sensitivity testing following the NFPA 72 (1999 edition) codes. The facility will ensure that all future inspections will be completed following the NFPA 72 (1999 edition) codes. This will be completed by March 19 th , 2013.	3/19/13	
K 052 88=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DOWJ21

Facility ID: 00129

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

PRINTED: 01/16/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 38 1/2 STREET SAINT LOUIS PARK, MN 55416		
(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 052	Continued From page 10 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to test and to properly document the test of the fire alarm system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 1999 edition, Sections 7-3.1, 7-3.2 and 7.5.2.2. This deficient practice could affect all 76 residents. Findings include: On 1/16/13 at 11:23am, review of the document titled "Park Health and Rehab Fire Alarm System 2012 Inspection" dated 5/15/12 revealed that the fire alarm system inspection report did not include all of the required information. The summary of the devices did not indicate the type of smoke detectors that were located in the facility. In addition, comparing the 2012 report with the 2011 report titled "Park Health and Rehab Fire Alarm System" dated 5/31/11 revealed there was a discrepancy in the number of smoke detectors that were located in the facility. The 2011 report indicated that there were 85 smoke detectors and the 2012 report indicates that there are 99 smoke detectors. When asked if any smoke detectors were added or removed between the time of the 2011 report and the 2012 report the Maintenance Director replied "No."	K 052	K- 54: 1. The fire alarm inspection contractor will do a complete assessment of all smoke detectors in the facility. An accurate count of detectors and the type of detector will be obtained. The fire contractor will then do an inspection of the entire system including sensitivity testing following NFPA 72 (1999 edition) codes. This will be completed by March 19 th , 2013. 2. Maintenance Director will be educated on the requirement of sensitivity testing by March 19 th , 2013. K-56: 1. The curtain in the northwest medical supply room was removed on 2/6/13. The abandoned sprinkler system will be removed from the laundry room area. Staffing office, 106, 108, and 121 will be sprinkled by March 19 th , 2013. 2. Director of Maintenance will inspect the rest of the building to make sure there are no other areas where there are two sprinklers close together and that curtains do not block sprinkler heads in closets. Other closets similar on the lower level were inspected and sprinkled. This will be completed by March 19 th , 2013.		3/19/13

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DOWJ21

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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 86 1/2 STREET SAINT LOUIS PARK, MN 55416		
(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 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.8.1.3 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to sensitivity test all of the fire alarm system smoke detectors in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.4 and 9.8 and NFPA 72 - 1999 edition, Section 7-3.2.1. This deficient practice could affect all 76 residents. Findings include: On 1/16/13 at 11:36pm, review of the documents titled "2012 Park Health and Rehab Annual Fire Inspection" dated 6/17/2010 revealed that the last smoke detector sensitivity test was conducted on that date. The smoke detectors were not tested for sensitivity within the last two years. This deficient practice was confirmed by the Facility Administrator and the Maintenance Director at the time of discovery.	K 054	3. Education will be completed with Maintenance Director on sprinkler system requirements, maintenance and ensuring that nothing blocks the passage of water from the sprinkler. Education will be completed by March 19th, 2013. 4. Audit will be conducted by Maintenance Director or designee, to make sure there are not curtains blocking the spray of fire sprinklers and that sprinklers are not too close together. 5. Results will be brought to QPI for further review by NHA or designee.	3/19/13	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 056			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/16/2013
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NAME OF PROVIDER OR SUPPLIER

PARK HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
4416 WEST 38 1/2 STREET
SAINT LOUIS PARK, MN. 55410

(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 DEFICIENCY IT IS MEANT TO CORRECT)	(X5) COMPLETION DATE
K 056	Continued From page 12 Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install the sprinkler system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.5 and 9.7; NFPA 13 - 1999 edition, Sections 5-1.1, 5-5.5, 5-5.5.2 and 5-5.5.4. This deficient practice could affect approximately 30 of the 76 residents. Findings include: 1. On 1/16/13 at 2:52pm, observation revealed that in the Medical Supply room by the northwest nurses station was divided into two sections by a solid curtain. One section was protected by a sprinkler that would also protect the second section but there was a solid curtain installed between the two sections that would obstruct the water spray from the sprinkler from reaching that area of the room. 2. On 1/16/13 at 3:30pm, observation revealed that closets in the staffing office and rooms 108, 109 and 121 were not sprinklered. At 3:31pm the Maintenance Director stated that "none of the closets in the rooms on the lower level were sprinklered."	K 056		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: D6WJ21

Facility ID: 00129

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

FORM APPROVED
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 38 1/2 STREET SAINT LOUIS PARK, MN 55416		
(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 058	Continued From page 13 3. On 1/16/13 at 3:40pm, observation revealed that in the laundry room there were at least four locations where two sprinklers were located 19" to 28" apart. These deficient practices were confirmed by the Facility Administrator and the Maintenance Director at the time of discovery. NFFA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFFA 18, NFFA 25, 9.7.6 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to maintain its automatic sprinkler system in accordance with NFFA 101 - 2000 edition, Sections 19.3.5 and 9.7 and NFFA 25 - 1998 edition, Sections 2.2.1.1 and 2-4.1.4. This deficient practice could affect approximately 30 of the 76 residents. Findings include: 1. On 1/16/13 at 3:20pm, observation revealed that the sprinkler in the kitchen dishwashing area was showing signs of corrosion. 2. On 1/16/13 at 3:42pm, observation revealed that a sprinkler in the laundry room was showing signs of corrosion. These deficient practices were confirmed by the	K 058	K- 62 1. Sprinkler head in laundry room and kitchen area were removed and replaced on 1/24/13. 2. Director of Maintenance inspected others in the building on 1/24/13 for erosion and replaced as needed. 3. Maintenance Director will be educated on looking for eroded sprinkler heads on rounds by March 19 th , 2013. 4. Audits will be conducted by the Maintenance Director or designee, to look for sprinkler heads that are showing signs of erosion. 5. Audits will be brought to QPI for further review by NHA or designee.	2/14/13	
K 062 SS-B		K 062			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DOWJ21

Facility ID: 00129

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

PRINTED: 01/25/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4418 WEST 80 1/2 STREET SAINT LOUIS PARK, MN 55418		
(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 062	Continued From page 14	K 062	K-67:	3/14/13	
K 067 SS-F	Facility Administrator and the Maintenance Director at the time of discovery. NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a heating air conditioning and ventilation system in accordance with NFPA 101 - 2000 edition, Section 19.5.2.1 and 9.2.1; as well as, NFPA 90A - 1999 edition sections 2-3.11 and 2-3.11.1. This deficient practice could affect all 76 residents. Finding include: On 1/16/13 at 1:45pm, observation revealed that the resident rooms had supply air only and a toilet exhaust that was operated by a pull chain switch. The corridors had return air only. When asked where the supply air from the corridor was returned the Maintenance Director said that the air supplied into the resident rooms was returned through the corridor. This air movement configuration moves air from the room to the corridor and uses the corridor as a plenum. Using the corridor as a plenum is not allowed by the code.	K 067	Park Health is requesting a Waiver for the corridor being used as an HVAC plenum. In addition to being a disruption to our residents, staff and visitors, this is also a financial hardship for this center. Please see attached waiver request. 1. Education has been completed with the Maintenance Director on the HVAC system requirements regarding the use of a corridor as a plenum by March 19 th , 2013. 2. Audit has been conducted by Licensed HVAC contractor. Please see attached: 3. Results of the audit have been received and it is determined to be a financial hardship and an unnecessary disruption to the centers residents, staff and visitors.		
K 143 SS-E	NFPA 101 LIFE SAFETY CODE STANDARD	K 143			

FORM OMB-2567(02-99) Previous Versions Obsolete

Event ID: BOWJ21

Facility ID: 00189

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

REVISION: 07/20/2013
FORM APPROVED
OMB NO. 0980-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248083	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER PAK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 35 1/2 STREET SAINT LOUIS PARK, MN 55416		
(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 143	Continued From page 15 Transferring of oxygen is: (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; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to store liquid oxygen in a room that was in accordance with the requirements of NFPA 99 - 1999 edition, Section 8-6.2.5.2. This deficient practice could affect approximately 30 of the 76 residents. Findings include: 1. On 1/16/13 at 9:22am, observation revealed an unattended half full large liquid oxygen canister was located in the corridor outside of room 221. At the time of the observation the Facility Administrator said that the canister was for a resident who had been discharged and it	K 143	K- 143: 1. Liquid O2 was taken out of office immediately on 1/16/13. 2. Maintenance Director will inspect other rooms to make sure there is no oxygen storage in hallways or offices. 3. Staff will be educated on appropriate oxygen storage by March 19th, 2013. 4. Audit will be conducted to ensure appropriate oxygen storage by the Maintenance Director or designee. 5. Results will be brought to monthly QPI meeting for review by NHA or designee.	3/19/13	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245088	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416		
(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 143	Continued From page 16 was sitting in the corridor until the oxygen company could come and pick it up. 2. On 1/16/13 at 1:30pm, observation revealed that a half full large liquid oxygen canister was located in the Admission office. At the time of observation the Facility Administrator said that this canister was the canister that was located outside of room 221 and was put in the Admission office until the oxygen company could pick it up. The Facility Administrator said it was put in the admission office because the liquid oxygen storage room was full and there was no room for it. When asked how often the liquid oxygen company visited the facility to pick up oxygen canisters she replied "Once or twice a week." NFFPA 101 LIFE SAFETY CODE STANDARD	K 143	K-144; Park Health is requesting a temporary waiver for the installation of our new generator. The electrician has ordered the correct generator and he will install it as upon receipt. We anticipate that this will be received and installed and tested by June 15, 2013 and request a temporary waiver until that time. The center will ensure that the monthly load test will contain proof that the generator is run with at least 30% of the nameplate rating for 30 minutes, has a remote enunciator, equipped with a battery powered light to provide illumination and will be able to check all necessary items to meet Life Safety Code requirements. Please see previously sent request and letter from Electrician. 1. Generator checklist currently in use and checking items that facility can check with current generator. Maintenance Director has checked areas that he is able to check on our current generator and all areas are functioning. The Emergency Generator Test is being completed weekly. 2. Maintenance Director will be educated on generator maintenance requirements and will ensure that all future inspections and tests will be done with the appropriate check sheet. This will be completed by June 15, 2013. 3. Audit will be conducted by NHA to ensure that generator checklist is completed. 4. Results will be brought to QPI for further review.	6/15/13	
K 144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to provide a remote annunciator for the emergency generator, failed to provide battery powered emergency lighting at the emergency generator and failed to test the emergency generator in accordance with the requirements of NFPA 101 - 2000 edition, section	K 144			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DOWJ21

Facility

01/20

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

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OMB NO. 0938-0891

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 38 1/2 STREET SAINT LOUIS PARK, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 144	Continued From page 17 19.5.1 and 9.1.3; NFPA 110 - 1999 edition, Sections 6-3, 5-3.1, 6-4, 6-4.1 and 6-4.2, as well as, NFPA 99 - 1999 edition section 3-4.1.1.15. This deficient practice could affect all 76 residents. Findings include: 1. On 1/16/13 at 11:58am, review of the document titled "Weekly Emergency Generator" for the last 12 months revealed that the only item checked weekly was the battery. Other items recommended to be visually inspected were not checked. 2. On 1/16/13 at 11:58am, review of the document titled "Weekly Emergency Generator" which the Maintenance Director said was used to document the monthly load test, revealed that the monthly load test was not at 30% of the nameplate rating for 30 minutes. 3. On 1/16/13 at 2:51pm, observation revealed that there was no remote annunciator for the newly installed (November 2012) generator. 4. On 1/16/13 at 3:08pm, observation revealed that the emergency generator was located outside on the side of the building and there was not enough room to pull a vehicle around that side of the building. There was no battery powered emergency light provide to illuminate the emergency generator. These deficient practices were confirmed by the Facility Administrator and the Maintenance Director at the time of discovery.	K 144	K-146: 1. A letter was received on 1/24 from Center Point Energy indicating a reliable fuel source and indicating a low likelihood of interruption and why both are true. The Maintenance Director will ensure that a copy of this letter be on hand at all times in the center.	3/19/13	
K 146	NFPA 101 LIFE SAFETY CODE STANDARD	K 146			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DOWJ21

Facility ID: 00129

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 55 1/2 STREET SAINT LOUIS PARK, MN 55416		
(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 146 SS=F	Continued From page 18 A nursing home or hospice with no life support equipment has 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. NFPA 99, 3.6.3.1.1 This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to provide a reliable fuel source for the emergency generator in accordance with the requirements of NFPA 101 - 2000 edition, section 10.5.1 and 9.1.3 and NFPA 99 - 1999 edition, Section 3-4.1.1.2. This deficient practice could affect all 76 residents. Findings Include: On 1/16/13 at 12:00pm, an interview with the Maintenance Director revealed that the fuel source for the emergency generator was natural gas. Review of the letter from Center Point Energy dated 12/1/06 revealed that the letter from the fuel supplier did not include all of the required items. There was no statement that the fuel source was reliable with a description as to why that was true. There was no statement that there was a low likelihood of an interruption with a statement as to why that was true. This deficient practice was confirmed by the Facility Administrator and the Maintenance Director at the time of discovery. NFPA 101 LIFE SAFETY CODE STANDARD	K 146	K- 154: 1. A new fire watch procedure has been written that addresses when the facilities automatic sprinkler system is out of service for more than 4 hours in a 24 hour period. This plan was obtained on 1/17/13. 2. Staff will be educated on this procedure by March 19 th , 2013. 3. Administrator will monitor to ensure that this policy is on hand and accessible to staff at all times.	3/19/13	
K 154 SS=F		K 154			

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245085	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2013
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 95 1/2 STREET SAINT LOUIS PARK, MN 55416		
(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 154	Continued From page 19 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to have a policy that addressed when the sprinkler system was out of service for more than four hours in a 24 hour period as required by NFPA 101 - 2000 edition Section 9.7.6.1. This deficient practice could affect all 76 residents. Findings include: On 1/16/13 at 10:42am, review of the document titled "Interim Fire Safety Plan (Fire Watch plan)" dated 12/21/09 revealed that the Interim Fire Safety Plan only addressed when the fire alarm system was out of service. The facility did not have a policy addressing when the sprinkler system was out of service. This deficient practice was confirmed by the Facility Administrator and the Maintenance Director at the time of discovery.	K 154			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DQWJ21

Facility ID: 00120

If continuation sheet Page 20 of 20

TOTAL P.25

Name of Facility

Park Health and Rehabilitation Center 4415 West 36 1/2 St. St. Louis Park, MN 55416

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 K-67 The building heating, ventilation, and air conditioning equipment (HVAC) does not comply with Life Safety Code (00), Section 9.2, and NGPA 90A, 1999 Edition, because the corridors are being used as a plenum.	An annual/continuing waiver is being requested for K067 for the following reasons: A. Compliance with this provision will cause an unreasonable hardship to the Center. 1. Facility received a bid from a mechanical engineer on 2/7/13. The cost would be \$141,840, which does not include wall patching, painting, sheet rock soffits around duct work and electrical wiring. A copy of this estimate is attached. B. Park Health and Rehabilitation believes that failure to correct this citations will not pose an undue safety risk to our residents and staff for the following reasons: 1. The facility is protected by an Automatic Sprinkler system that protects the entire building. 2. The facility is protected by a smoke and fire detection system that protects the entire building, alarms internally when smoke or fire is detected, and is monitored by an outside contractor who notifies the fire department in the case of an alarm. 3. The air handling unit that supplies these hallways that are used as a plenum is connected to this fire alarm system and shuts down when there is an alarm. This shut down negates the airflow and the hallways as a plenum. 4. The facility is located less than a mile from the nearest fire station and the fire department response time to the facility is less than 4 minutes. 5. The facility has a comprehensive written fire plan that staff is trained on upon hire and annually after hire. We believe that for these reasons, not correcting this cite poses no undue safety threat to our residents or staff.

Surveyor (Signature)	Title	Office	Date
Fire Authority Official (Signature)	Title	Office	Date

[Signature], NHA 2/7/13

Legacy

Companies, Inc.

8850 Wentworth Avenue South, Bloomington, MN 55420
Phone (612) 866-1351 Fax (612) 866-6829

February 7, 2013

Park Health Center
4415 W 86 ½ St.
St. Louis Park, MN 55416
Attn: Kristie Johnsrud

Subj: Return Air Ductwork

Dear Kristie,

Legacy Co presents for your consideration the following proposal to revise the existing return air ducting at the Park Health Center. This proposal is based on my discussion with Chris Walsh today and my site inspection.

We propose to install galvanized steel return air ductwork in the ceiling of the patient rooms thru out the entire facility. This will work, but you will be lowering the existing ceiling height in portions of all the rooms. The ductwork will be exposed and will have to be shifted as it goes from room to room to avoid lights and sprinklers.

We will furnish and install the following:

1. Rectangular exposed galvanized steel return air ductwork.
2. Approximately (80) return air grilles.
3. Capping off existing hall grilles and reconfiguring the ductwork within the mechanical rooms.
4. Wall cutting.
5. Balancing of ductwork.
6. Necessary supervision, drayage, engineering and permit.

We will do this work for the sum of **ONE HUNDRED FORTY ONE THOUSAND, EIGHT HUNDRED, FORTY AND 00/100 DOLLARS (\$141,840.00).**

Work not included is wall patching, painting, sheet rock soffits around ductwork and electrical wiring if necessary.

Should you have any questions please contact me.

Very truly yours,



Grant Petersen
Project Manager

GP U:PHCRA

Design-Build • Heating • Air Conditioning • Controls • 24 Hr Service

Ebel, Shawn R

From: Grant <grant@legacymech.net>
Sent: Friday, February 08, 2013 9:23 AM
To: Johnsrud, Kristie M; Ebel, Shawn R
Subject: Re: Return Air Ductwork at Park Health and Rehabilitation Center

Kristie/Shawn,

After discussion with Clint in our office the possibility of the fire marshal requiring smoke and fire dampers between each of the rooms is a possibility, if that is required it would be necessary to install up to (80) smoke and fire dampers.

If that is necessary there would be an additional cost of \$44,000.00 plus electrical wiring.

I can incorporate this into my letter I sent yesterday if that would help you with your appeal.

Grant Petersen

----- Original Message -----

From: Grant Petersen
To: kjohnsrud@extendicare.com ; Shawn Ebel
Sent: Thursday, February 07, 2013 4:30 PM
Subject: Return Air Ductwork at Park Health and Rehabilitation Center

Kristie/Shawn

Attached is the cost of installing return air ductwork thru out your facility, to accomplish this it will be necessary to do a lot of coordination in moving patients as we would progress thru the building. If your want me to go into detail in the letter the difficulties this would cause you I can rewrite it.

Grant Petersen
Project Manager

Legacy Co.

Cell 612-708-9401
Office 612-866-1351
Fax 612-866-6829

This e-mail has been scanned by Verizon Managed Email Content Service, using Skeptic(tm) technology powered by MessageLabs. For more information on Verizon's Managed Email Content Service, visit <http://www.verizonbusiness.com>.

The statement below is in reference to Park Health and Rehabilitation Center requesting a waiver for K-067. It explains the financial hardship placed upon the center to correct the citation K-067.

Park Health and Rehabilitation Center does not have the finances required to upgrade the HVAC system to meet code for a balanced system. A statement provided by Group Controller for Extendicare shows that Park Health and Rehabilitation Center had a Net Operating Income of \$1,516,148.00 for the year 2012: Revenue \$7,847,160 and Expenses \$6,331,012

The current HVAC upgrade is at a cost of \$141,840.00. If a HVAC upgrade was done, it would be with air conditioning added to meet the demand of today's society. A cost estimate is provided by Grant Petersen, Project Engineer, of Legacy Companies Inc. Please see attached engineer estimate.

K-067 will not adversely affect the health and safety of the resident/personnel of Park Health and Rehab because of the following:

- It has a fully functioning fire alarm system.
- Park Health and Rehab has smoke detectors in the corridors every 30', resident rooms, and common areas throughout the building.
- The Fire Alarm System is monitored by a monitoring company upon activation of the fire alarm.
- The building has a quick response sprinkler system fully throughout.
- Financial hardship does not allow the center to upgrade the HVAC System equipment that would be required to meet K-067. Please see attached statement proving financial hardship.
- The construction that would be required to upgrade the HVAC System would cause unnecessary disruption and hardship to the lives of the residents of the facility.

In addition, Park Health and Rehabilitation Center will conduct Fire Drills at rate of 1 per shift per month. Park Health and Rehabilitation Center will practice evacuation of the smoke zone to an adjacent safe smoke zone with every fire drill. Also, Park Health and Rehabilitation Center will practice complete building evacuation 2 times per year.

The statement below is in reference to Park Health and Rehabilitation Center requesting a waiver for K-067. It explains the financial hardship placed upon the center to correct the citation K-067.

Park Health and Rehabilitation Center does not have the finances required to upgrade the HVAC system to meet code for a balanced system. A statement provided by Group Controller for Extendicare shows that Park Health and Rehabilitation Center had a Net Operating Income of \$1,516,148.00 for the year 2012: Revenue \$7,847,160 and Expenses \$6,331,012

The current HVAC upgrade is at a cost of \$141,840.00. If a HVAC upgrade was done, it would be with air conditioning added to meet the demand of today's society. A cost estimate is provided by Grant Petersen, Project Engineer, of Legacy Companies Inc. Please see attached engineer estimate.



January 24, 2013

Chris Walsh
Extendicare
4415 West 36 1/2 Street
St Louis Park, MN 55416

Subject: Reliability of Natural Gas Supply
Firm Meter #M19670277086, Account #5792319

The natural gas service CenterPoint Energy provides has been and continues to be reliable in our service area. This natural gas system is designed to deliver natural gas supplies to all firm customers, even during periods of severe cold temperatures when the demand for natural gas is at its peak. This natural gas system can accommodate Extendicare's firm natural gas needs including the natural gas emergency back-up generator under full fuel load. Network modeling software and actual system conditions are used to identify areas where system reliability could be a concern. Once areas of reliability concern are discovered, plans are developed and executed to address the issue.

There is a low probability of interruption of the natural gas. Occasionally there are situations that can cause an unplanned or planned natural gas outage. Both of these situations are rare. For an unplanned outage, CenterPoint Energy uses all available resources to restore natural gas service in a reasonable amount of time. For a planned outage such as required maintenance, CenterPoint Energy will notify you in advance and try to make arrangements to accommodate your specific needs.

CenterPoint Energy's natural gas system is designed, installed, operated and maintained in compliance with company policies and federal and state regulations. These safety and reliability measures provide protection to the natural gas system and helps to ensure a continuous supply of natural gas to all firm customers including Extendicare in St Louis Park.

Please feel free to contact me with any questions or concerns.

Sincerely,

A handwritten signature in black ink, appearing to read "David Henningsgaard". The signature is fluid and cursive.

David Henningsgaard, P.E.
Engineer 5
CenterPoint Energy Minnesota Region
700 Linden Avenue West
Minneapolis, Minnesota 55403
612-321-5316

3/12/13

Division of Survey and Certification
233 North Michigan Ave. Suite 600
Chicago, IL 60601

Dear Mr. Wexelberg:

RE: K-144 Temporary waiver request

Due to circumstances beyond our control we would like to amend our plan of correction and request a temporary waiver for K-144.

When you conducted our survey we had recently had a new emergency generator installed. The annunciator panel had not been installed at the time of the survey. We were told by the electrician that once the new panel was installed it would give us the information that we needed to inspect and record during our generator test (i.e. oil pressure, water temperature, etc). Our initial plan of correction stated we would use a new check sheet to record this information. Once the annunciator was installed it did not give us everything we needed. The electrician has been working with the generator manufacturer to provide us with an annunciator that would. We were informed by the electrician that converting the generator to fit the annunciator would void the warranty. During the ordering of the generator either the electrician did not make it clear that this was a life safety installation or the generator company sent the wrong generator. The electrician has ordered the correct generator and he will install it as upon receipt. We anticipate that this will be received and installed and tested by June 15, 2013 and request a temporary waiver until that time.

Please be assured that in the mean time, we do have an emergency generator that runs all of the necessary equipment and systems. It will be tested every week and under load every month. All items will be visually inspected weekly and we will record all the information it does provide. There has been an emergency battery back-up light installed at the location of the generator. Once the new generator is installed we will use the new check sheet to ensure all items recommended are inspected weekly. We will be able to prove and record that the generator is running at 30% of the rated capacity every month.

Attached is a letter from the electrician explaining what happened. Please accept this as our amended plan of correction for K-144 and our request for a temporary waiver until June 15, 2013.

Respectfully,



Kristie Johnsrud, NHA

AEM ELECTRIC SERVICES

Corporation

1630 County Road 10 N.E. Suite 103 Spring Lake Park, MN 55432 (763) 783-7080 Fax 783-1381

Extendicare health Facilities Inc.

111 West Michigan Street

Milwaukee WI

Attn: Tom Gilbride

Re: Park Health

4415 36 1/2 street

St. Louis Park MN

Tom,

In reference to the generator unit we installed at your facility, this is what took place. The unit was supposed to be an industrial unit with NFPA compliance. In ordering the unit there was some confusion in my description of what was needed here. I thought that my supplier was asking me if we needed the unit to be dual fuel critical branch and I had replied that it did not have to be that unit. He took this to mean we could use a commercial generator and this was shipped out and installed on site.

Since then I had been working to have the installed unit converted to the proper controller in the field which was the plan since the unit is the same as the industrial unit but without all of the controller features.

I had contracted with a local generator service company who was to do the install but when they went to order the parts to do this work they were told by Generac Corporation that they would not sell the parts to convert this unit in the field or warranty the unit if it was converted.

This left us with no other choice but to order a complete new unit which I have done through total energy and the order has been placed with Kohler Generator.

I am told that the new unit would be available for install at around 8 weeks from the order date so at this time I see no reason that we will not have the new generator installed and on site prior to June 1 2013.

LICENSED • BONDED • INSURED

Hope this helps explain what happened here and please rest assured we will continue to do everything possible to correct this problem in the shortest amount of time possible.

Sincerely,

A handwritten signature in black ink, appearing to read 'David Schoenrock', written in a cursive style.

David Schoenrock

AEM Electric Services Inc.

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 60L1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00129

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN# 24-5083

At the time of the standard survey completed December 24, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.

Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 8953 7235

January 4, 2013

Ms. Kristie Johnsrud, Administrator
Park Health and Rehabilitation Center
4415 West 36 1/2 Street
Saint Louis Park, Minnesota 55416

RE: Project Number S5083023 and H5083049

Dear Ms. Johnsrud:

On December 24, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the December 24, 2012 standard survey the Minnesota Department of Health completed an investigation of complaint number H5083049. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the December 24, 2012 standard survey the Minnesota Department of Health completed an investigation of complaint number H5083049 that was found to be unsubstantiated.

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gloria Derfus
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 2, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by March 20, 2013 (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 June 20, 2013 (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

Park Health And Rehabilitation Center

January 4, 2013

Page 6

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Shellae Dietrich".

Shellae Dietrich, Program Specialist

Licensing and Certification Program

Division of Compliance Monitoring

Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

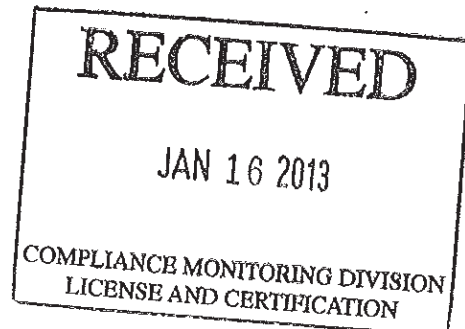
cc: Licensing and Certification File

5083s13.rtf

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

PRINTED: 01/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/20/2012
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A standard recertification survey was conducted and complaint investigation was also completed at the time of the standard survey. An investigation of complaint H5083049 was completed. The complaint was not substantiated.	F 000	Park Health and Rehab Center submits this plan of correction because it is required by State and Federal Regulation and is not a legal admission that this statement of deficiencies is correctly cited, and is not to be construed as an admission against the interest by the Center, the Administrator or any employees, agents or other individuals who draft or may be discussed in the response and plan of correction. Park Health and Rehabilitation respectfully submits this plan of correction and our allegation of compliance as of February 1 st , 2013.	01/04/2013 REVISED 00391	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329		2/15/13	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE: *Kristal Johnson* TITLE: *Administrator* (X6) DATE: *1/15/13*

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

PRINTED: 01/04/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245083	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2012
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NAME OF PROVIDER OR SUPPLIER

PARK HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

4415 WEST 36 1/2 STREET

SAINT LOUIS PARK, MN 55416

(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 329	Continued From page 1 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 10 residents (R91) drug regimen was free from unnecessary medications. Findings include: R91's diagnoses included dementia, anxiety and depression. R91 was observed asleep in bed on 12/18/12, at 1:45 p.m., 2:48 p.m., and 3:04 p.m. R91 received more than the recommended amount of Ativan (a medication used for anxiety). On 12/19/12, at 12:34 p.m. R91 was observed quietly feeding herself lunch in the dining room, no signs or symptoms of anxiety were noted. R91 was observed to be quietly lying awake in bed on 12/19/12, at 1:27 p.m. On 12/20/12, at 8:02 a.m. R91 was observed sitting quietly in her wheel chair. At 8:07 a.m. R91 was observed sitting at the table in the dining room, holding her head and moaning quietly. No signs or symptoms of anxiety were noted. A nurse practitioner note (NP) dated 1/13/12, indicated sertraline (an antidepressant	F 329	F329 1. Resident #91 is no longer at the center. 2. All residents on Ativan will be reviewed by Feb 1, 2013. When the doctor declines a gradual dose reduction, interdisciplinary team will review for further assessments, documentation or action as needed. 3. Education will be completed with licensed staff, IDT team and NP on unnecessary medication recommendations by February 1, 2013.. 4. Audits will be conducted weekly on outstanding recommendations for unnecessary medications, for 4 weeks. Then, monthly upon receipt of recommendation from pharmacy. Audits will be conducted by Director of Nursing or designee. 5. Results will be brought to QA for further review by the Administrator or designee.	01/04/2013 PROVID 0938-0391

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NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416
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F 329

Continued From page 2

medication) was increased last month "in hopes that we could eventually decrease the lorazepam [Ativan] that she has scheduled every 4 hrs [hours] WA [while awake]." The plan given was to give sertraline more time to work and to continue lorazepam as scheduled. The same note also indicated an order was written for R91 to have psychiatric services "but the family would have to pay privately and they did not want to do this."

A Target Behavior Program Summary Report with a date range of 9/21/12 through 12/19/12, indicated R91 had a target behavior of "Repetitive anxiousness- Res [resident] will ask repetitively where her family is or what she should do. She will appear worried about schedules and routine. Interventions- offer one to one support, redirect res [resident] to an activity. Remind res [resident] her family knows where she is and will be coming to visit." The summary report showed the target behavior occurred between 06:30-14:30 on 10/18/12, 11/1/12, 11/2/12, 11/3/12, 11/7/12, 11/20/12, 11/21/12, 12/11/12, 12/13/12 and 12/16/12. The summary report showed that the target behavior occurred between 14:30-22:30 only on 10/14/12, and never occurred between 22:30-06:30.

A social service progress note dated 9/27/12, indicated R91 had a room change and was "doing well upstairs." A social service progress note dated 12/4/12, indicated R91 had a target behavior of repetitively asking where family was/worried about schedule and routine. The progress note indicated that the target behavior occurred two times in August 2012, eight times in September 2012, two times in October 2012 and six times in November 2012.

F 329

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 329	Continued From page 3 A Pharmacy Consultation Report dated 11/12/12, recommended a gradual dose reduction of Ativan be attempted. The consultant's report did not identify that R91 received 3 mg of Ativan daily nor did it identify that R91 received Ativan at 12:00 a.m. and 4:00 a.m. The NPs response to the consultation report dated 11/19/12, was "Patient is anxious at all times when she is awake. Daughter [dtr]/POA [power of attorney] is aware of risks of medication and requests that her mother remain on med [medication] @ [at] current dose. Dtr/staff have noted improvement and stability of pt. [patient] on this regimen." The care plan for R91, last revised on 11/27/12, indicated R91 received Ativan for "repetitive anxiousness; repetitive questions, concerns about family; calling out help cont. [continuously]." The care plan also indicated that R91 had depression with anxiety and received Zoloft (an antidepressant medication) for "calling out help me saying she is lonesome and crying." In addition, the care plan indicated R91 "wants someone to sit with her @ all times when she has company she falls asleep." The interventions included one on one with activities, daughter visits almost daily, and invited to all activities. A NP note dated 11/27/12, indicated R91 received 0.5 milligrams (mg) while awake per Hospice. The note also indicated R91 was on Hospice several months ago and scheduled Ativan was started. The NP note does not indicate the total amount of Ativan received per day. The physician's orders dated December 2012 for	F 329			

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F 329	Continued From page 4 R91 included an order for Ativan 0.5 mg every four hours while awake. The medication administration record (MAR) for December 2012 showed that R91 received Ativan at 8:00 a.m., 12:00 p.m., 4:00 p.m., 8:00 p.m., 12:00 a.m., and 4:00 a.m., for a total dose of 3 mg daily. A facility progress note dated 9/17/12, indicated R91 was "sleeping well." A facility progress note dated 12/12/12, indicated R91 "slept well." The clinical record lacked any facility progress notes from 9/21/12 through 12/19/12, regarding anxiety for R91. A quarterly minimum data set (MDS) dated 12/6/12, showed that R91 had a brief interview of mental status (BIMS) score of 3 indicating severe cognitive impairment. The quarterly MDS also showed that R91 had other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) one-three days during the seven day period ending 11/29/12. The quarterly MDS also indicated that R91 was "feeling down, depressed, or hopeless" 12-14 days, was "feeling tired or having little energy" two-six days and did not have "trouble falling or staying asleep, or sleeping too much" during the 14 day period ending 11/29/12. Registered nurse (RN)-B was interviewed on 12/19/12, at 1:51 p.m. and indicated she did not recall ever being told by the night shift that R91 was awake at night.	F 329			

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F 329	Continued From page 5 RN-C stated during an interview on 12/20/12, at 9:37 a.m. stated she had never been told R91 had difficulty sleeping at night. Sleep logs were requested from RN-D on 12/20/12, at 9:45 a.m. When interviewed on 12/20/12, at 10:32 a.m. RN-D stated that there were no sleep logs for R91 because Ativan was being used for anxiety not sleep and R91 must be awake at night or the Ativan would be held. When interviewed on 12/20/12, at 10:54 a.m. licensed social worker (LSW)-A stated that R91 had "less calling out since a room change around August or September" and R91 was taken to activities or one on one visits were provided as R91 "says she is lonely when calling out. "LSW-A also stated R91 "says she moans because it makes people pay attention to her." The pharmacy consultant was interviewed on 12/20/12, at 11:17 a.m. The pharmacy consultant stated that she had requested a gradual dose reduction of R91's Ativan in November 2012 which the NP declined. The pharmacy consultant also indicated that the maximum recommended dose of Ativan for use in geriatrics was 2 mg per day. When queried as to what a while awake order indicated, she stated that a period of sleep would be expected. When interviewed on 12/21/12, at 3:00 p.m. the NP stated that a while awake order was intended to be between the hours of 8:00 a.m. and 8:00 p.m. The NP stated she was unaware R91 received Ativan at 12:00 a.m. and 4:00 a.m. and it was not her intent that R91 be given Ativan at those times. The NP further stated she "would	F 329			12/20/13 APPROVED 0391 12/20/13 APPROVED 0391 12/20/13 APPROVED 0391

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F 329	Continued From page 6 need to be more specific with my orders." The NP agreed that 2 mg was the maximum recommended geriatric dose of Ativan and that R91 received 3 mg daily with the 12:00 a.m. and 4:00 a.m. doses.	F 329			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416			
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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Park Health and Rehab Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid, 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. Park Health and Rehab Center is a 2-story building with no basement. The building was constructed in 1960 and was determined to be of Type II (111) construction. In 1970 an addition was constructed and was determined to be of Type II (000) construction. In 1998 an addition was constructed and was determined to be of Type II (111) construction. It is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitor for fire department notification. Because the construction height and fire protection systems allow for Type II (000) construction, the facility was surveyed as 1 building. The facility has a capacity of 81 beds with a census of 72 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.			K 000			

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

TITLE

(X6) DATE

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



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 8953 7235

January 4, 2013

Ms. Kristie Johnsrud, Administrator
Park Health and Rehabilitation Center
4415 West 36 1/2 Street
Saint Louis Park, Minnesota 55416

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5083023 and H5083049

Dear Ms. Johnsrud:

The above facility was surveyed on December 17, 2012 through December 20, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5083023 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Park Health And Rehabilitation Center

January 4, 2013

Page 2

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5083s13.rtf

Minnesota Department of Health

TITLE

(X6) DATE

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

STATE FORM

6899

60L111

If continuation sheet 1 of 14

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/20/2012
NAME OF PROVIDER OR SUPPLIER PARK HEALTH AND REHABILITATION CENTE		STREET ADDRESS, CITY, STATE, ZIP CODE 4415 WEST 36 1/2 STREET SAINT LOUIS PARK, MN 55416		
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2 000	Continued From page 1 Certification Programs; 85 East Seventh Place, Suite 220; P.O. Box 64900, St. Paul, Minnesota 55164-0900. An investigation of complaint H5083049 was completed during the standard survey. The complaint was not substantiated.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21400	MN Rule 4658.0810 Subp. 1 Resident Tuberculosis Program Subpart 1. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Informational Bulletin 09-02 Tuberculosis Prevention and Control Guidelines: Nursing Homes, Minnesota Rule 4658.0810 Subpart 1 Resident Tuberculosis Program is waived. Conditions of Waiver:	21400	Corrections will be made by Feb 1 st , 2013 for state licensing violations.  1/15/13	

Minnesota Department of Health

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21400	Continued From page 2 - All residents must receive baseline TB screening within 72 hours of admission or within 3 months prior to admission. TB Screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms, and a two-step TST or a single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold In Tube, T-SPOT®.TB). Routine serial TB screening of residents may be done at the discretion of the infection control team. - All reports and copies of resident tuberculin skin tests (TSTs), results from IGRAs for M. tuberculosis, medical evaluations, and chest radiograph results must be maintained in the resident's medical record. Consult current CDC recommendations for the diagnosis of TB for recommended follow-up of residents who display signs or symptoms of active TB disease. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete a two-step tuberculin skin test (TST) for 2 of 5 residents (R67, R124) and to ensure tuberculosis (TB) symptom assessments were completed for 5 of 5 residents (R67, R108, R124, R74, R68) whose TB testing records were reviewed. Findings include:	21400			

Minnesota Department of Health

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21400	Continued From page 3 R67 was admitted to the facility on 2/12/11. Upon review of R67's record, R67 received a TST on 2/18/11, which was read on 2/20/11. A second step was not documented in R67's record. A TB symptom assessment was not completed for R67. R124 was admitted to the facility on 9/26/12. R124's record revealed that a first step TST was given on 9/27/12, and read on 9/29/12. A second step was noted as given on 10/24/12; no date was noted for when this step had been read. R108 was admitted to the facility on 6/11/11. Upon review of R108's record, a two-step TST was completed upon admission; however, a TB symptom assessment was not completed. R74 was admitted to the facility on 9/11/12. Upon review of R74's record, a two-step TST was completed upon admission; however, a TB symptom assessment was not completed. R68 was admitted to the facility on 7/27/12. Upon review of R68's record, a two-step TST was completed upon admission; however, a TB symptom assessment was not completed. On 12/20/12, at 1:56 p.m. the registered nurse (RN)-E verified that a two-step TST had not been completed for R67 and R124. In addition, RN-E stated no risk assessments were completed for new residents. The procedure for Tuberculosis Screening-Residents last revised November 2011, was reviewed. The procedure directed "Extendicare Health Services, Inc. [EHSI] will administer the two-step Mantoux Purified Protein Derivative (PPD) Test to all new residents as required by State Regulations on admission unless they have documented evidence of a previous positive skin test." The procedure does not include symptom assessments for new residents. Suggested Method for Correction: The	21400			

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21400	Continued From page 4 administrator or designee could review the facility system in place to ensure newly admitted residents receive the tuberculin test as required by state rule. Revise the system as needed and educate staff on the system in place. Monitor and review the delivery of the mantoux and adjust the system as needed. Time Period for Correction: Twenty one (21) days.	21400			
21415	MN Rule 4658.0815 Subp. 2 Employee Tuberculosis Program Subp. 2. Pursuant to Minnesota Rule 4658 0040 and as defined in Minnesota Department of Health Informational Bulletin 09-02, Minnesota Rule 4658.0815 Subpart 2 Employee Tuberculosis Program is waived. Conditions of Waiver: - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive baseline TB screening. This screening must include a written assessment of any current TB symptoms, and a two-step tuberculin skin test (TST) or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold - In Tube, T-SPOT® .TB). - All paid and unpaid HCWs (as defined in the "CDC Guidelines") must receive serial TB screening based on the facility's risk level: (1) low risk - not needed; (2) medium risk - yearly; (3) potential ongoing transmission - consult the Minnesota Department of Health's TB Prevention and Control Program at 651-201-5414. · HCWs with abnormal TB screening results	21415			

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21415	Continued From page 5 must receive follow-up medical evaluation according to current CDC recommendations for the diagnosis of TB. See www.cdc.gov/tb · All reports or copies of HCW TSTs, IGRAs for M. tuberculosis, medical evaluation, and chest radiograph results must be maintained in the HCW 's employee file. · All HCWs exhibiting signs or symptoms consistent with TB must be evaluated by a physician within 72 hours. These HCWs must not return to work until determined to be non-infectious. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) symptom assessments were completed and a two-step tuberculin skin test (TST) were read correctly for 5 of 5 employees whose files were reviewed for TB screening. Findings include: The registered nurse (RN)-H was hired on 9/13/12. Upon review of the employee file, a TB symptom assessment was not completed for the employee. The first step TST was given on 9/13/12, and the result was read as (-) "negative"	21415			

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21415	Continued From page 6 on 9/15/12. The second step TST was given on 10/1/12, and the result was read as (-) "negative" on 10/4/12. RN-G was hired on 10/3/12. Upon review of the employee file, a TB symptom assessment was not completed for the employee. The first step TST was given on 10/3/12, and the result was read as (-) "negative" on 10/5/12. The second step TST was given on 10/17/12, and the result was read as (-) "negative" on 10/19/12. The dietary aide (DA)-A was hired on 10/3/12. Upon review of the employee file, a TB symptom assessment was not completed for the employee. The first step TST was given on 10/3/12, and the result was read as (-) "negative" on 10/5/12. The second step TST was given on 10/17/12, and the result was read as (-) "negative" on 10/20/12. RN-F was hired on 11/14/12. Upon review of the employee file, a TB symptom assessment was not completed for the employee. The first step TST was given on 11/14/12, and the result was read as (-) "negative" on 11/16/12. The second step TST was given on 11/28/12, and the result was read as (-) "negative" on 11/30/12. The licensed practical nurse (LPN)-B was hired on 11/14/12. Upon review of the employee file, a TB symptom assessment was not completed for the employee. The first step TST was given on 11/14/12, and the result was read as (-) "negative" on 11/16/12. The second step TST was given on 11/28/12, and the result was read as (-) "negative" on 11/30/12. When interviewed on 12/20/12, at 9:15 a.m. the facility infection control nurse (RN)-E verified that the employee TST tests were read as (-) "negative" and that there were no millimeters of induration documented for the employees reviewed. On 12/20/12, at 1:56 p.m. RN-E also verified that there were no symptom assessments	21415			

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21415	Continued From page 7 completed for the employees reviewed. The procedure for Tuberculin Skin Test last revised July 2012, was reviewed. The procedure directed to "measure the induration in millimeters." Suggested Method for Correction: The administrator or designee could review the facility system in place to ensure new employees are screened and the tuberculin test are read according to CDC guidelines as required by state rule. Revise the system as needed and educate staff on the system in place. Monitor and review the delivery of the mantoux and adjust the system as needed. Time Period for Correction: Twenty-one (21) days.	21415			
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992.	21535			

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21535	Continued From page 8 This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 10 residents (R91) drug regimen was free from unnecessary medications. Findings include: R91's diagnoses included dementia, anxiety and depression. R91 was observed asleep in bed on 12/18/12, at 1:45 p.m., 2:48 p.m., and 3:04 p.m. R91 received more than the recommended amount of Ativan (a medication used for anxiety). On 12/19/12, at 12:34 p.m. R91 was observed quietly feeding herself lunch in the dining room, no signs or symptoms of anxiety were noted. R91 was observed to be quietly lying awake in bed on 12/19/12, at 1:27 p.m. On 12/20/12, at 8:02 a.m. R91 was observed sitting quietly in her wheel chair. At 8:07 a.m. R91 was observed sitting at the table in the dining room, holding her head and moaning quietly. No signs or symptoms of anxiety were noted. A nurse practitioner note (NP) dated 1/13/12, indicated sertraline (an antidepressant medication) was increased last month "in hopes that we could eventually decrease the lorazepam [Ativan] that she has scheduled every 4 hrs [hours] WA [while awake]." The plan given was to give sertraline more time to work and to continue	21535			

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21535	Continued From page 9 lorazepam as scheduled. The same note also indicated an order was written for R91 to have psychiatric services "but the family would have to pay privately and they did not want to do this." A Target Behavior Program Summary Report with a date range of 9/21/12 through 12/19/12, indicated R91 had a target behavior of "Repetitive anxiousness- Res [resident] will ask repetitively where her family is or what she should do. She will appear worried about schedules and routine. Interventions- offer one to one support, redirect res [resident] to an activity. Remind res [resident] her family knows where she is and will be coming to visit." The summary report showed the target behavior occurred between 06:30-14:30 on 10/18/12, 11/1/12, 11/2/12, 11/3/12, 11/7/12, 11/20/12, 11/21/12, 12/11/12, 12/13/12 and 12/16/12. The summary report showed that the target behavior occurred between 14:30-22:30 only on 10/14/12, and never occurred between 22:30-06:30. A social service progress note dated 9/27/12, indicated R91 had a room change and was "doing well upstairs." A social service progress note dated 12/4/12, indicated R91 had a target behavior of repetitively asking where family was/worried about schedule and routine. The progress note indicated that the target behavior occurred two times in August 2012, eight times in September 2012, two times in October 2012 and six times in November 2012. A Pharmacy Consultation Report dated 11/12/12, recommended a gradual dose reduction of Ativan be attempted. The consultant's report did not identify that R91 received 3 mg of Ativan daily nor did it identify that R91 received Ativan at 12:00 a.m. and 4:00 a.m. The NPs response to the	21535			

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21535	Continued From page 10 consultation report dated 11/19/12, was "Patient is anxious at all times when she is awake. Daughter [dtr]/POA [power of attorney] is aware of risks of medication and requests that her mother remain on med [medication] @ [at] current dose. Dtr/staff have noted improvement and stability of pt. [patient] on this regimen." The care plan for R91, last revised on 11/27/12, indicated R91 received Ativan for "repetitive anxiousness; repetitive questions, concerns about family; calling out help cont. [continuously]." The care plan also indicated that R91 had depression with anxiety and received Zoloft (an antidepressant medication) for "calling out help me saying she is lonesome and crying." In addition, the care plan indicated R91 "wants someone to sit with her @ all times when she has company she falls asleep." The interventions included one on one with activities, daughter visits almost daily, and invited to all activities. A NP note dated 11/27/12, indicated R91 received 0.5 milligrams (mg) while awake per Hospice. The note also indicated R91 was on Hospice several months ago and scheduled Ativan was started. The NP note does not indicate the total amount of Ativan received per day. The physician's orders dated December 2012 for R91 included an order for Ativan 0.5 mg every four hours while awake. The medication administration record (MAR) for December 2012 showed that R91 received Ativan at 8:00 a.m., 12:00 p.m., 4:00 p.m., 8:00 p.m., 12:00 a.m., and 4:00 a.m., for a total dose of 3 mg daily. A facility progress note dated 9/17/12, indicated R91 was "sleeping well." A facility progress note	21535			

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21535	Continued From page 11 dated 12/12/12, indicated R91 "slept well." The clinical record lacked any facility progress notes from 9/21/12 through 12/19/12, regarding anxiety for R91. A quarterly minimum data set (MDS) dated 12/6/12, showed that R91 had a brief interview of mental status (BIMS) score of 3 indicating severe cognitive impairment. The quarterly MDS also showed that R91 had other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) one-three days during the seven day period ending 11/29/12. The quarterly MDS also indicated that R91 was "feeling down, depressed, or hopeless" 12-14 days, was "feeling tired or having little energy" two-six days and did not have "trouble falling or staying asleep, or sleeping too much" during the 14 day period ending 11/29/12. Registered nurse (RN)-B was interviewed on 12/19/12, at 1:51 p.m. and indicated she did not recall ever being told by the night shift that R91 was awake at night. RN-C stated during an interview on 12/20/12, at 9:37 a.m. stated she had never been told R91 had difficulty sleeping at night. Sleep logs were requested from RN-D on 12/20/12, at 9:45 a.m. When interviewed on 12/20/12, at 10:32 a.m. RN-D stated that there were no sleep logs for R91 because Ativan was being used for anxiety not sleep and R91 must be awake at night or the Ativan would be held.	21535			

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21535	Continued From page 12 When interviewed on 12/20/12, at 10:54 a.m. licensed social worker (LSW)-A stated that R91 had "less calling out since a room change around August or September" and R91 was taken to activities or one on one visits were provided as R91 "says she is lonely when calling out. "LSW-A also stated R91 "says she moans because it makes people pay attention to her." The pharmacy consultant was interviewed on 12/20/12, at 11:17 a.m. The pharmacy consultant stated that she had requested a gradual dose reduction of R91's Ativan in November 2012 which the NP declined. The pharmacy consultant also indicated that the maximum recommended dose of Ativan for use in geriatrics was 2 mg per day. When queried as to what a while awake order indicated, she stated that a period of sleep would be expected. When interviewed on 12/21/12, at 3:00 p.m. the NP stated that a while awake order was intended to be between the hours of 8:00 a.m. and 8:00 p.m. The NP stated she was unaware R91 received Ativan at 12:00 a.m. and 4:00 a.m. and it was not her intent that R91 be given Ativan at those times. The NP further stated she "would need to be more specific with my orders." The NP agreed that 2 mg was the maximum recommended geriatric dose of Ativan and that R91 received 3 mg daily with the 12:00 a.m. and 4:00 a.m. doses. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee could develop policies and procedures, educate staff, and conduct random audits of resident medication regimens to ensure compliance with state and federal regulatory requirements.	21535			

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21535	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535			