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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7P9V

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00557

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245554**

2.STATE VENDOR OR MEDICAID NO.
(L2) **792697900**

3. NAME AND ADDRESS OF FACILITY
(L3) **RENVILLA HEALTH CENTER**
(L4) **205 SOUTHEAST ELM AVENUE**
(L5) **RENVILLE, MN** (L6) **56284**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2005**

6. DATE OF SURVEY **04/23/2012** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **46** (L18)

13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	46			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Marge Meeker, Unit Supervisor 05/22/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege,Program Specialist 05/22/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/20/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN: 24-5554

Item 16 Continuation for CMS-1539

At the time of the standard survey completed on March 13, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On April 23, 2012, the Minnesota Department of Health completed a Post Certification Revisit (by review of the plan of correction), and on April 11, 2012, the Minnesota Department of Public Safety completed a Post Certification Revisit. It was determined that the facility had achieved substantial compliance pursuant to the standard survey completed on March 13, 2012, effective April 5, 2012. Therefore, the remedies outlined in our letter dated March 21, 2012 will not be imposed. See attached CMS-2567B for the results of the April 23, 2012 and April 11, 2012 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5554

May 22, 2012

Mr. James Ingersoll, Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, Minnesota 56284

Dear Mr. Ingersoll:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 5, 2012 the above facility is recommended for:

46 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 46 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Nicole Steege

Nicole Steege, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone #: (651) 201-4124 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 22, 2012

Mr. James Ingersoll, Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, Minnesota 56284

RE: Project Number S5554023

Dear Mr. Ingersoll:

On March 21, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 8, 201. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 23, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 11, 2012 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 8, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 5, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 8, 2012, effective April 5, 2012 and therefore remedies outlined in our letter to you dated March 21, 2012, will not be imposed.

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

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,

Marge Meeker

Marge Meeker, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7317 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File 5554R12

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245554	A. Building B. Wing	4/23/2012

Name of Facility	Street Address, City, State, Zip Code
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

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 **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **04/05/2012**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **04/05/2012**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **04/05/2012**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **04/05/2012**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **04/05/2012**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/05/2012**
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** MM/NCS	**Date:** 5/22/12	**Signature of Surveyor:** 03020	**Date:** 4/23/12
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/8/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245554	01 - MAIN BUILDING 01	4/11/2012

Name of Facility	Street Address, City, State, Zip Code
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0052	03/17/2012	ID Prefix Reg. # NFPA 101 LSC K0069	03/17/2012	ID Prefix Reg. # NFPA 101 LSC K0072	04/03/2012
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/NCS	5/22/12	22373	4/11/12
CMS RO				

Followup to Survey Completed on: 3/13/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245554	02 - 2008 RESIDENT WING ADDITION	4/11/2012

Name of Facility	Street Address, City, State, Zip Code
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0052	03/17/2012	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/NCS	Date: 5/22/12	Signature of Surveyor: 22373	Date: 4/11/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/13/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7P9V

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00557

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245554**

2.STATE VENDOR OR MEDICAID NO.
(L2) **792697900**

3. NAME AND ADDRESS OF FACILITY
(L3) **RENVILLA HEALTH CENTER**
(L4) **205 SOUTHEAST ELM AVENUE**
(L5) **RENVILLE, MN** (L6) **56284**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2005**

6. DATE OF SURVEY **03/13/2012** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **46** (L18)

13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	46			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Marilyn Kaelke, HFE NE II 04/10/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Susan N. Leppke, Program Specialist 04/18/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/20/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

At the time of the standard survey completed on March 13, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are 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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8043 8928

March 21, 2012

Mr. James Ingersoll, Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, Minnesota 56284

RE: Project Number S5554023

Dear Mr. Ingersoll:

On March 13, 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Marge Meeker
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301-4557

Telephone: (320) 223-7317

Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 17, 2012, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 17, 2012 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by

the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 June 8, 2012 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 8, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific

deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Marge Meeker

Marge Meeker, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7317 Fax: (320) 223-7348

Enclosure

cc: Licensing and Certification File 5554s12.rtf

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Informal Dispute Requested

This facility has requested an Informal Dispute on the tag(s) identified below.

Facility (City) HFID#	Exit Date Being Disputed	Tag# - Scope/Severity Disputed
Renvilla Health Center 00557	3/8/2012	~~F280 – D~~ ~~F318 – D~~

Larson, Monica (MDH)

From: pschilling@sfhs.org
Sent: Thursday, March 29, 2012 10:06 AM
To: *MDH_FPC-IDR
Subject: IDR Form

PROVIDER - 00557, RENVILLA HEALTH CENTER

IDR Type - IDR

Tags: FF280 and F318
Survey Date(Exit Date): 03/08/2012

Review will be conducted - In writing

Dates when facility cannot participate:

Will attorney for facility be attending: No

No of persons attending:
Submitter Name: Priscilla Schilling
Email:pschilling@sfhs.org

Priscilla
Phone # 320 760 9232
Fax #

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 30, 2012

Mr. James Ingersoll,
Renvilla Health Center
205 Southeast Elm Avenue
Renville, MN 56284

Dear Mr. Ingersoll:

This letter acknowledges receipt of your request for Informal Dispute Resolution (IDR) of the deficiencies issued at a recent Minnesota Department of Health survey of your facility.

It is my understanding that you are contesting the validity of the following:

F280 = D
F318 = D

I have assigned the responsibility for the IDR to Gary Nederhoff . Gary will contact you regarding the scheduling of the meeting or feel free to contact him at 507-206-2731.

Sincerely,

Mary Absolon

Mary Absolon, Program Manager
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone : (651) 201-4100 FAX: (651) 215-9697

cc: Office of Ombudsman for Long-Term Care
Pam Kerssen, Assistant Program Manager
Carol Moen, Assistant Program Manager
Gary Nederhoff, Unit Supervisor
Monica Larson

00557IDR

MINNESOTA
MDH
DEPARTMENT of HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7003 2260 0000 9987 6937
May 21, 2012

Mr. James Ingersoll, Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, Minnesota 56284

Subject: Renvilla Health Center - IDR
Provider # 24-5554
Project # S5554023

Dear Mr. Ingersoll:

This is in response to your request of an informal dispute resolution (IDR) for the federal deficiencies at tag F280 and F318 issued pursuant to the survey event 7P9V11, completed on March 8, 2012.

The information presented with your letter, the CMS 2567 dated March 8, 2012 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff and a phone call with staff from the facility on April 16, 2012 at 11:00 a.m. have been carefully considered and the following determination has been made:

F280 (D) 42 CFR §483.10(d)(3) – The resident has the right to -- unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.

Based on information reviewed, R3 was receiving physical therapy to assess the use and benefit of lower extremity positioning boots during the survey. The directions/instructions for the use of the lower extremity positioning boots would not have been added to the resident's care plan until after physical therapy had completed their assessment and developed a plan for use of the boots. R3 refused to wear the lower positioning boots and immediately following the survey exit on March 8, 2012 the lower extremity positioning boots were determined to be of no benefit due to the residents refusals to wear the boots.

This is not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies on the CMS-2567 form and state licensing order form MN 4658.0405 Subp. 4.

F318 (D) 42 CFR §483.25(e)(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

R3 was receiving physical therapy at the time of the survey to assess the need for use of the lower extremity positioning boots. Since the resident was still in the process of being assessed by physical therapy for the use of the positioning boots, a plan of intervention/directions would not have been developed and formalized until this assessment period was completed. Shortly after the survey exit on March 8, 2012 physical therapy determined the resident would not benefit from the use of the boots as R3 refused to wear them.

This is not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies on the CMS-2567 form and state licensing order form MN 4658.0525 Subp. 2.B.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Gary Nederhoff

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 507-206-2731 Fax: 507-206-2711

cc: Office of Ombudsman for Long-Term Care
Carol Moen, Assistant Program Manager
Licensing and Certification File
Marge Meeker, Statewide Survey Team Unit Supervisor

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245554	A. Building B. Wing	4/23/2012

REVISED 5/21/12

Name of Facility	Street Address, City, State, Zip Code
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

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 F0167 Reg. # 483.10(g)(1) LSC	Correction Completed 04/23/2012	ID Prefix F0176 Reg. # 483.10(n) LSC	Correction Completed 04/23/2012	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 04/23/2012
ID Prefix F0356 Reg. # 483.30(e) LSC	Correction Completed 04/23/2012	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 04/23/2012	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 04/23/2012
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	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 3/8/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING _____ B. WING _____	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

(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 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 ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000	REVISED 5/21/2012	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not ensure survey results were readily accessible for residents and families to examine. This had the potential to effect 46 of 46 residents who resided in the facility.	F 167		4/5/12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING _____ B. WING _____	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 167	Continued From page 1 Findings include: Facility survey results were observed to be inaccessible for residents and families to examine, without having to ask to see them. During initial tour observations at 2:05 p.m. on 3/5/12, the survey results were not available for review without having to ask the facility. Upon request, the health unit coordinator (HUC)-A located a three-ring-binder that was masked by the branches of two potted plants placed on either side of it. It was located on the nurse's station countertop. The outward facing cover of the three-ring binder was not labeled. The opposite cover of the three-ring-binder did identify the contents as survey results. There was no sign posted to direct individuals on how to find the survey results. The three-ring-binder was fastened to a chain that was connected beneath the inside of the nurse's station countertop. The chain measured approximately 15 inches in length. The chain did not allow for the three-ring binder to be moved from the countertop. Therefore it could not be lowered to a level that would be visible for individuals who utilized wheelchairs, or to be reviewed in private. During interview at 2:15 p.m. on 3/6/12, director of nursing (DON) acknowledged that the survey results were not easily accessible to all residents. The DON reported that the facility used to have the results in a bin attached to the wall, next to the South nurse's station. It had a longer chain that allowed for the results to be easily reviewed by all residents. The DON was unaware of when or why this was changed. On 3/7/12 with permission from Resident 36	F 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING _____ B. WING _____	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 167	Continued From page 2 (R36) the resident council meeting minutes were reviewed for the months of 11/11, 12/11, 1/12, 2/12 and 3/12. The minutes had no mention of the facility survey results; who may read them, or where they were kept in the facility. The facility provided four resident names who would regularly attend resident council meetings, (R36, R17, R12, R37). The council did not appoint officers or have a chairperson. All four residents lacked exposure to, or knowledge of, the facility survey results and were unable to answer the resident council interview questions. At 12:08 p.m. on 3/7/12, R36 was unable to answer and shook her head when she was asked if the survey results were accessible without assistance from facility staff. R36 was not sure what facility survey results were. R36 was unaware of where the facility survey results were kept; therefore had never read the facility survey results or discussed the facility survey results with facility employees. The additional three resident names provided by the facility, were also interviewed to determine if the residents had knowledge of and where facility survey results were kept in the facility. On 3/8/12, at 10:10 a.m. R17 was interviewed; at 10:40 a.m. R12 was interviewed; and at 10:55 a.m. R 37 was interviewed. The three residents were also unable to identify the location of the survey results.	F 167		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this	F 176		4/5/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING _____ B. WING _____	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

(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 176	Continued From page 3 practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to determine if the practice of self-administration of medications was safe for 1 of 1 resident (R3) in the sample observed self-administering medication. Findings include: R3 was observed to self-administer a nebulizer treatment. The resident lacked a self-administration of medications assessment. A trained medication assistant (TMA)-B was observed at 9:38 a.m. on 3/7/12 to take a vial of DuoNeb (a medication that is used to aid breathing) into R3's room, pour the medication into a nebulizer machine, place the face mask on R3 and start the nebulizer machine. TMA-B informed R3, she (the TMA) would be setting an alarm on her medication cart and when the alarm went off, she would return and remove the mask. An interview at 9:41 a.m. on 3/7/12 with TMA-B, revealed R3 had a history of removing the mask prior to the nebulizer treatment being completed. R3's entry minimum data set (MDS) dated 2/7/12 , indicated R3 required extensive assistance or total dependence with activities of daily living, other than eating and use of electric wheelchair. R3 was independent in those areas. R3 was moderately impaired of cognition. R3's physician orders dated 2/29/12 included	F 176		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING _____ B. WING _____	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 176	Continued From page 4 DuoNeb Inhalation Solution qid (four times per day). There was no physician order authorizing R3 to self-administer medications. An interview with the director of nursing (DON) at 9:57 a.m. on 3/7/12 was completed. The DON verified that R3 was self-administering the nebulizer and an assessment should be done prior to doing so. The DON verified that an assessment had not been done. The facility's policy, dated 2/10, indicated the facility is to assess any resident who wishes to self-administer medication to ensure the resident is safe to do so. The policy also directed staff document on the medication record (MAR) or the treatment record (TAR) if the resident is able to self-administer medication. There was no documentation on the MAR or TAR for R3 to self administer medications.	F 176		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and	F 323		4/5/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING _____ B. WING _____	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 5 each resident received adequate supervision and assistive devices to prevent accidents for 4 of 5 residents (R8, R19, R20, R3) in the sample who utilized anti roll wheelchair brake devices. Findings include: R8, R19, R20 and R3 utilized anti roll (Safe*t Mate) wheelchair brake devices that were not properly adjusted to prevent the wheelchair from rolling backwards when the residents attempted to self transfer to/from the wheelchair. R8 had diagnoses that included diabetes mellitus, cerebrovascular accident (CVA) with hemiparesis, and recent fall history. The most recent annual minimum data set (MDS) dated 12/7/11, identified R8 with severe cognitive impairment (brief interview mental status BIMS=1) and extensive assistance of one staff for transfers. R8 had a fall history during self transfer to/from wheelchair on 12/12/11 and the fall risk assessment, dated 3/2/12, identified R8 at high risk for falls. Equipment needs on the assessment did not indicate use of anti roll wheelchair brakes; however, information from the post fall review noted these devices were applied as an intervention after the fall on 12/12/11. The anti roll brakes were noted during the environmental tour at 1:30 p.m. on 3/7/12 to not function properly when the resident was out of the wheelchair. The malfunction was verified by the maintenance director during the tour. R19 had diagnoses that included heart failure and CVA history.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING _____ B. WING _____	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 6 The quarterly MDS, dated 2/2/12, identified R19 with moderately impaired cognitive skills (BIMS=12), required supervision for transfers and balance was not steady during transitions. R19 did have a history of falls at the time of admission to the facility but had not fallen in the past six months. R19 was noted to have a wheelchair with anti roll brakes applied. The functional status of the anti roll brakes was reviewed during the environmental tour at 1:30 p.m. on 3/7/12. The anti roll brakes did not function properly when the resident was out of the wheelchair. The malfunction was verified by the maintenance director during the tour. R20 had diagnoses that included hypertension, diabetes mellitus and dementia. The quarterly MDS, dated 12/14/11, identified R20 with severe cognitive impairment (BIMS=6), extensive assistance for transfers and balance was not steady during transitions. R20 did not have a fall history within the past six months. R20 was noted to have a wheelchair with anti roll brakes applied. The functional status of the anti roll brakes was reviewed during the environmental tour at 1:30 p.m. on 3/7/12. The anti roll brakes did not function properly on the left wheel when the resident was out of the wheelchair and it could roll and turn when weight was applied. The	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING _____ B. WING _____	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

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F 323	Continued From page 7	F 323		

malfunction was verified by the maintenance director during the tour.

R39 had diagnoses that included diabetes mellitus and atrial fibrillation.

The quarterly MDS, dated 1/23/12, identified R39 with severe cognitive impairment (BIMS=4), extensive assistance of one staff for transfers and balance not steady during transitions. R39 did not have a fall history within the past six months.

R39 was noted to have a wheelchair with anti roll brakes applied.

The anti roll brakes did not function properly on the right rear wheel. Following the environmental tour on 3/7/12, the maintenance director verified the chair did not function properly on the right rear wheel when the resident was out of the wheelchair and it could roll and turn when weight was applied.

The maintenance director verified during interview during the environmental tour on 3/7/12, therapy generally took care of the wheelchairs and stated, "If it's a brake issue, I put on the anti roll brakes, they work pretty well and once in a while don't work and therapy will let me know and I will fix it right away." The maintenance director also verified there were both older and newer styles of anti roll brakes made by Safe*t mate. He indicated he was not aware the anti roll brakes were not properly adjusted for R8, R19, R20 and R39 and had not received any requests from nursing to fix them. The malfunctioning anti roll brakes included both the older and the newer

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RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

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F 323	Continued From page 8 designs. The maintenance director was not aware of any training provided for the direct care staff on how the anti roll brakes functioned and when a referral should be made to maintenance. The Safe*t Mate manufacturer's manual dated 2004 noted, "The anti rollback device should be inspected periodically to ensure that all the mounting hardware is securely tightened and the brake arms are in proper adjustment."	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356		4/5/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING _____ B. WING _____	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

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F 356	Continued From page 9 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure posted nurse staffing data included all specified information, related to total and actual hours worked by required category. This had the potential to effect 46 of 46 residents who resided in the facility. Findings include: Review of the facility's posted Daily Nursing Schedules, dated 3/5/12 and 3/6/12, revealed the nurse staffing data lacked identification of the total number and actual hours worked by category of licensed and unlicensed nursing staff, including registered nurses, licensed practical nurses and nurse's aides. The posting instead identified each individual scheduled shift time, categorized by day/evening/night shift, location within the facility and "team" number or employee title. The posting also included the first names of employees who were scheduled for each individual shift time. During interview at 2:10 p.m. on 3/6/12, health unit coordinator (HUC)-A verified she was responsible for posting the facility's nurse staffing data. HUC-A reported that she did not realize the facility's format for posted nurse staffing data did not meet regulation.	F 356		
F 371	483.35(i) FOOD PROCURE,	F 371		4/5/12

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	245554	A. BUILDING _____ B. WING _____	03/08/2012

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F 371 SS=F	Continued From page 10 STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure store, prepare, distribute and serve food under sanitary conditions. This had the potential to affect 46 of 46 residents in the facility. Findings include: The facility did not date food items stored in the refrigerator, record temperatures of refrigerators on both the north and south dining rooms, ensure the cleanliness of the north kitchenette and serve/distribute food to residents in a sanitary manner. During initial tour at 1:45 p.m. on 3/5/12, undated food items were observed in the refrigerator, located in the South dining room. Sliced cheese was noted to be in an unlabeled, undated Ziploc bag in the refrigerator door. Two open, half-full maple syrup bottles were also located in the refrigerator door and were noted to be undated.	F 371		

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F 371	Continued From page 11 A temperature log, dated 3/12 was taped to the outside of the refrigerator door. The temperature log lacked records of refrigerator temperatures for 3/1/12 through 3/5/12. The temperature at the time of observation was noted as 40 degrees Fahrenheit (F). During interview at 5:40 p.m. on 3/5/12, the director of dietary (DD) reported that a family member must have brought the sliced cheese into the facility and put it in the facility's refrigerator. DD added, "We don't even have that kind of cheese here." DD verified that the syrup bottles should have been dated with the date they were opened. DD verified the refrigerator temperatures were not being checked and recorded daily, as per the facility's policy. DD reported that the dietary aides were responsible for checking the refrigerators on a daily basis to ensure food items were stored or disposed of as appropriate. DD added, dietary aides were also responsible for checking and recording the refrigerator temperatures on a daily basis. Review of the facility's Food Labeling Policy and Procedure, dated 7/1/11, revealed that all foods needed to have a label and date on the container that was to be stored in the cooler or freezer. All packages/boxes needed to be labeled, identifying what was inside and the date opened. The policy added that any open container without an opened date on it would be thrown away immediately. Review of the facility's undated policy for Record of Refrigeration Temperatures, revealed that the dietary manager was to assign an employee to record all refrigerator and freezer temperatures on a daily basis.	F 371		

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F 371	Continued From page 12 At 4:22 p.m. on 3/5/12, the north kitchenette was toured. The refrigerator in the kitchenette had spilled juice/milk and a sticky substance on the shelves. A large dried brown substance was also observed on the floor of the base of the sink cabinet. The floor in the corner of the kitchenette under a wheeled dietary cart had a large amount of dried food debris. At 7:15 a.m. on 3/7/12, the debris beneath the wheeled food cart and the spilled juice/milk and the sticky substance on the shelves of the refrigerator was still present. An interview with dietary aide (DA)-C was completed. DA-C verified the spills in the refrigerator and the large food debris under the dietary cart. DA-C reported the dietary staff are responsible to spot clean the refrigerator, whenever they put food items into it. DA-C thought that the housekeeping staff was responsible for cleaning everything else in the kitchenette. At 7:55 a.m. on 3/7/12, an interview with the dietary manager (DM) was completed. DM verified the interior of the refrigerator was not clean and had milk/juice spills and a sticky substance on the shelf. DM reported that the dietary staff is to ensure the cleanliness of the interior of the kitchen. DM reported she had talked to the dietary staff and discovered that the spot cleaning had not been done the past two days. DM also reported that no schedule was in place for deep cleaning of the refrigerator by the dietary staff. DM indicated the housekeeping staff is responsible for cleaning everything in the kitchenette, other than the interior of the refrigerator. DM verified that floor by wheeled food cart had significant debris build up and the	F 371		

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F 371	Continued From page 13 base of the cabinet under the sink was dirty. At 11:44 a.m. 3/7/12, an interview with housekeeping staff (HS)-A was completed. HS-A reported she was responsible for the cleanliness of the kitchenette on the north wing. She reported she cleaned the floor daily, generally after the noon meal. HS-A verified the build up of debris on the floor. HS-A attempted to remove the wheeled cart from the kitchenette but was unable to do so. After HS-A was unable to remove the wheeled cart from the kitchenette, she attempted to clean under the cart with a broom. The broom did not reach all the debris under and surrounding the cart in the alcove. During the evening meal of 3/5/12 on the Centennial unit, several staff were noted to serve food without disinfecting/washing hands between serving multiple residents and after touching the residents, furniture and ready to serve/eat food items. The evening supper meal observation beginning at 5:25 p.m. on 3/5/12 included ham salad on a bun, sandwich, soup, coleslaw and french fries. Observation of dietary staff-A (DA-A) who served the meal revealed use of gloves; however, during the course of serving the meal, DA-A was noted to touch shelving, her clothing items and other nearby surfaces and then used the gloved fingers to remove the ham salad on to the plate for residents who did not want a bun. No utensils were used to scrape the ham salad off the buns. In addition, nursing assistants (NA) -A, and C were observed to deliver food to each resident seated at the tables without washing or	F 371		

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F 371	Continued From page 14 disinfecting hands between the contacts. During the delivery process, NA-A and NA-C were noted to touch residents, resident's clothing, their own clothing, furniture items and other surfaces as well as bare hand contact with the burger buns and sandwiches. Upon returning to the serving area, no hand washing or alcohol based disinfection was observed. NA-A was also observed to deliver food to resident's rooms without disinfection noted before serving others.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441		4/5/12

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F 441	Continued From page 15 (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infections (use and cleaning of community electric razors) in one of four bathing rooms. This practice had the potential to affect four residents in the facility. Finding include: At 3:15 p.m. on 3/5/12, three electric razors were observed on a table in the tub room on the north wing of the facility. One of the electric razors had a significant build up of hair in the head of the razor. An interview with nursing assistant (NA)-E was completed at 3:15 p.m. on 3/5/12. NA-E reported the community razor is used on most of the resident but a few residents have their own razors. NA-E reported the razors were to be cleaned after each resident use, but was unsure of the procedure to do so. NA-E verified the significant build up of hair and described the	F 441		

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F 441	Continued From page 16 condition of the head of the razor as "gross." At 4:56 p.m. on 3/5/12, an interview with the director of nursing (DON) was completed. The DON reported that she believed most of the residents at the facility had their own razors. The DON indicated if a community razor is used, the razor is to be cleaned with alcohol between each resident use. The DON verified the presence of the three community razors in the north tub room and also indicated that the debris build up on one of the razors was not acceptable and needed to be cleaned. The facility policy and procedure labeled "Cleaning Razors", dated 11/09, was received. The policy indicated the facility was to "make sure resident razors and facility razors are cleaned and disinfected to prevent spread of infection." The procedure for cleaning facility razors directed staff, after each resident use to open the top of the razor and clean off excess hair from inside the razor with razor brush. Staff were then instructed to wipe off the outside of the razor with alcohol pad and allow to dry. This was not followed.	F 441		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On, March 5,6,7 and 8, 2012, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	REVISED 5/21/2012	

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2 000	Continued From page 1 Certification Program: 3333 West Division St. Suite 212, St. Cloud, MN 56301-4557	2 000		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure store, prepare, distribute and serve food under sanitary conditions. This had the potential to affect 46 of 46 residents in the facility. Findings include: The facility did not date food items stored in the refrigerator, record temperatures of refrigerators on both the north and south dining rooms, ensure the cleanliness of the north kitchenette and serve/distribute food to residents in a sanitary manner. During initial tour at 1:45 p.m. on 3/5/12, undated food items were observed in the refrigerator, located in the South dining room. Sliced cheese was noted to be in an unlabeled, undated Ziploc bag in the refrigerator door. Two open, half-full maple syrup bottles were also located in the refrigerator door and were noted to be undated. A temperature log, dated 3/12 was taped to the outside of the refrigerator door. The temperature log lacked records of refrigerator temperatures	21015		

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21015	Continued From page 2 for 3/1/12 through 3/5/12. The temperature at the time of observation was noted as 40 degrees Fahrenheit (F). During interview at 5:40 p.m. on 3/5/12, the director of dietary (DD) reported that a family member must have brought the sliced cheese into the facility and put it in the facility's refrigerator. DD added, "We don't even have that kind of cheese here." DD verified that the syrup bottles should have been dated with the date they were opened. DD verified the refrigerator temperatures were not being checked and recorded daily, as per the facility's policy. DD reported that the dietary aides were responsible for checking the refrigerators on a daily basis to ensure food items were stored or disposed of as appropriate. DD added, dietary aides were also responsible for checking and recording the refrigerator temperatures on a daily basis. Review of the facility's Food Labeling Policy and Procedure, dated 7/1/11, revealed that all foods needed to have a label and date on the container that was to be stored in the cooler or freezer. All packages/boxes needed to be labeled, identifying what was inside and the date opened. The policy added that any open container without an opened date on it would be thrown away immediately. Review of the facility's undated policy for Record of Refrigeration Temperatures, revealed that the dietary manager was to assign an employee to record all refrigerator and freezer temperatures on a daily basis. At 4:22 p.m. on 3/5/12, the north kitchenette was toured. The refrigerator in the kitchenette had spilled juice/milk and a sticky substance on the shelves. A large dried brown substance was also	21015		

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21015	Continued From page 3 observed on the floor of the base of the sink cabinet. The floor in the corner of the kitchenette under a wheeled dietary cart had a large amount of dried food debris. At 7:15 a.m. on 3/7/12, the debris beneath the wheeled food cart and the spilled juice/milk and the sticky substance on the shelves of the refrigerator was still present. An interview with dietary aide (DA)-C was completed. DA-C verified the spills in the refrigerator and the large food debris under the dietary cart. DA-C reported the dietary staff are responsible to spot clean the refrigerator, whenever they put food items into it. DA-C thought that the housekeeping staff was responsible for cleaning everything else in the kitchenette. At 7:55 a.m. on 3/7/12, an interview with the dietary manager (DM) was completed. DM verified the interior of the refrigerator was not clean and had milk/juice spills and a sticky substance on the shelf. DM reported that the dietary staff is to ensure the cleanliness of the interior of the kitchen. DM reported she had talked to the dietary staff and discovered that the spot cleaning had not been done the past two days. DM also reported that no schedule was in place for deep cleaning of the refrigerator by the dietary staff. DM indicated the housekeeping staff is responsible for cleaning everything in the kitchenette, other than the interior of the refrigerator. DM verified that floor by wheeled food cart had significant debris build up and the base of the cabinet under the sink was dirty. At 11:44 a.m. 3/7/12, an interview with housekeeping staff (HS)-A was completed. HS-A reported she was responsible for the cleanliness of the kitchenette on the north wing. She reported	21015		

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21015	Continued From page 4 she cleaned the floor daily, generally after the noon meal. HS-A verified the build up of debris on the floor. HS-A attempted to remove the wheeled cart from the kitchenette but was unable to do so. After HS-A was unable to remove the wheeled cart from the kitchenette, she attempted to clean under the cart with a broom. The broom did not reach all the debris under and surrounding the cart in the alcove. During the evening meal of 3/5/12 on the Centennial unit, several staff were noted to serve food without disinfecting/washing hands between serving multiple residents and after touching the residents, furniture and ready to serve/eat food items. The evening supper meal observation beginning at 5:25 p.m. on 3/5/12 included ham salad on a bun, sandwich, soup, coleslaw and french fries. Observation of dietary staff-A (DA-A) who served the meal revealed use of gloves; however, during the course of serving the meal, DA-A was noted to touch shelving, her clothing items and other nearby surfaces and then used the gloved fingers to remove the ham salad on to the plate for residents who did not want a bun. No utensils were used to scrape the ham salad off the buns. In addition, nursing assistants (NA) -A, and C were observed to deliver food to each resident seated at the tables without washing or disinfecting hands between the contacts. During the delivery process, NA-A and NA-C were noted to touch residents, resident's clothing, their own clothing, furniture items and other surfaces as well as bare hand contact with the burger buns and sandwiches. Upon returning to the serving area, no hand washing or alcohol based	21015		

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21015	Continued From page 5 disinfection was observed. NA-A was also observed to deliver food to resident's rooms without disinfection noted before serving others. A SUGGESTED METHOD FOR CORRECTION: The administrator and/or dietician could review and revise food service policies and procedures to assure that food is stored and served in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager could monitor the service of food on a periodic basis. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infections (use and cleaning of community electric razors) in one of four bathing rooms. This practice had the potential to affect four residents in the facility. Finding include: At 3:15 p.m. on 3/5/12, three electric razors were observed on a table in the tub room on the north wing of the facility. One of the electric razors had a significant build up of hair in the head of the	21375		

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(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) COMPLETE DATE
21375	Continued From page 6 razor. An interview with nursing assistant (NA)-E was completed at 3:15 p.m. on 3/5/12. NA-E reported the community razor is used on most of the resident but a few residents have their own razors. NA-E reported the razors were to be cleaned after each resident use, but was unsure of the procedure to do so. NA-E verified the significant build up of hair and described the condition of the head of the razor as "gross." At 4:56 p.m. on 3/5/12, an interview with the director of nursing (DON) was completed. The DON reported that she believed most of the residents at the facility had their own razors. The DON indicated if a community razor is used, the razor is to be cleaned with alcohol between each resident use. The DON verified the presence of the three community razors in the north tub room and also indicated that the debris build up on one of the razors was not acceptable and needed to be cleaned. The facility policy and procedure labeled "Cleaning Razors", dated 11/09, was received. The policy indicated the facility was to "make sure resident razors and facility razors are cleaned and disinfected to prevent spread of infection." The procedure for cleaning facility razors directed staff, after each resident use to open the top of the razor and clean off excess hair from inside the razor with razor brush. Staff were then instructed to wipe off the outside of the razor with alcohol pad and allow to dry. This was not followed. Suggested Method of Correction: The infection preventionist or designee could review policies and procedures to ensure proper infection	21375		

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	00557	A. BUILDING _____ B. WING _____	03/08/2012

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21375	Continued From page 7 control techniques are followed. Facility staff could be reeducated and an auditing system developed to ensure compliance. Time Period for Correction: Twenty one (21) days.	21375		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to determine if the practice of self-administration of medications was safe for 1 of 1 resident (R3) in the sample observed self-administering medication. Findings include: R3 was observed to self-administer a nebulizer treatment. The resident lacked a self-administration of medications assessment. A trained medication assistant (TMA)-B was observed at 9:38 a.m. on 3/7/12 to take a vial of DuoNeb (a medication that is used to aid breathing) into R3's room, pour the medication into a nebulizer machine, place the face mask on R3 and start the nebulizer machine. TMA-B informed R3, she (the TMA) would be setting an alarm on her medication cart and when the alarm went off, she would return and remove the mask.	21565		

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21565	Continued From page 8 An interview at 9:41 a.m. on 3/7/12 with TMA-B, revealed R3 had a history of removing the mask prior to the nebulizer treatment being completed. R3's entry minimum data set (MDS) dated 2/7/12 , indicated R3 required extensive assistance or total dependence with activities of daily living, other than eating and use of electric wheelchair. R3 was independent in those areas. R3 was moderately impaired of cognition. R3's physician orders dated 2/29/12 included DuoNeb Inhalation Solution qid (four times per day). There was no physician order authorizing R3 to self-administer medications. An interview with the director of nursing (DON) at 9:57 a.m. on 3/7/12 was completed. The DON verified that R3 was self-administering the nebulizer and an assessment should be done prior to doing so. The DON verified that an assessment had not been done. The facility's policy, dated 2/10, indicated the facility is to assess any resident who wishes to self-administer medication to ensure the resident is safe to do so. The policy also directed staff document on the medication record (MAR) or the treatment record (TAR) if the resident is able to self-administer medication. There was no documentation on the MAR or TAR for R3 to self administer medications. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review and revise the policies and procedures for the resident self-administration assessment/protocol and care planning, educate the appropriate personnel in any changes and appoint a designee to monitor the procedures to ensure ongoing compliance.	21565		

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21565	Continued From page 9 TIME PERIOD FOR CORRECTION: Thirty (30) days.	21565		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS THE FACILITY 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 ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not ensure survey results were readily accessible for residents and families to examine. This had the potential to effect 46 of 46 residents who resided in the facility.	F 167 OK 4/4/12 MM	F167 Corrective Action: 1. Annual survey results were made accessible to all residents and visitors on 3/6/12. All surfaces of the binder labeled so may be identified as to its contents. Binder is now placed in box fastened to wall at a level that will be visible to individuals who utilize wheelchairs, or to be taken to be reviewed in private.. Systemic Action: 1. The annual survey results binder will be discussed at the next resident council meeting on 4/5/12 and then at the monthly meetings thereafter. 2. Staff will be educated on having the survey results readily accessible to residents and visitors. 3. Audits will be completed weekly x4 then monthly. 4. Results of audits will be reported in QI meetings quarterly. The QI team will make recommendations for ongoing monitoring. 5. Person Responsible: DON 6. Compliance date	April 3,4,5 April 5

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

4-3-12

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.

U:\Jim\MDH\2012 Survey\MDH\FTag 167 Plan of Correction 2012.docx

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F 167	Continued From page 1 Findings include: Facility survey results were observed to be inaccessible for residents and families to examine, without having to ask to see them. During initial tour observations at 2:05 p.m. on 3/5/12, the survey results were not available for review without having to ask the facility. Upon request, the health unit coordinator (HUC)-A located a three-ring-binder that was masked by the branches of two potted plants placed on either side of it. It was located on the nurse's station countertop. The outward facing cover of the three-ring binder was not labeled. The opposite cover of the three-ring-binder did identify the contents as survey results. There was no sign posted to direct individuals on how to find the survey results. The three-ring-binder was fastened to a chain that was connected beneath the inside of the nurse's station countertop. The chain measured approximately 15 inches in length. The chain did not allow for the three-ring binder to be moved from the countertop. Therefore it could not be lowered to a level that would be visible for individuals who utilized wheelchairs, or to be reviewed in private. During interview at 2:15 p.m. on 3/6/12, director of nursing (DON) acknowledged that the survey results were not easily accessible to all residents. The DON reported that the facility used to have the results in a bin attached to the wall, next to the South nurse's station. It had a longer chain that allowed for the results to be easily reviewed by all residents. The DON was unaware of when or why this was changed. On 3/7/12 with permission from Resident 36	F 167		

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F 167	Continued From page 2 (R36) the resident council meeting minutes were reviewed for the months of 11/11, 12/11, 1/12, 2/12 and 3/12. The minutes had no mention of the facility survey results; who may read them, or where they were kept in the facility. The facility provided four resident names who would regularly attend resident council meetings, (R36, R17, R12, R37). The council did not appoint officers or have a chairperson. All four residents lacked exposure to, or knowledge of, the facility survey results and were unable to answer the resident council interview questions. At 12:08 p.m. on 3/7/12, R36 was unable to answer and shook her head when she was asked if the survey results were accessible without assistance from facility staff. R36 was not sure what facility survey results were. R36 was unaware of where the facility survey results were kept; therefore had never read the facility survey results or discussed the facility survey results with facility employees. The additional three resident names provided by the facility, were also interviewed to determine if the residents had knowledge of and where facility survey results were kept in the facility. On 3/8/12, at 10:10 a.m. R17 was interviewed; at 10:40 a.m. R12 was interviewed; and at 10:55 a.m. R 37 was interviewed. The three residents were also unable to identify the location of the survey results.	F 167		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this	F 176		

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F 176	Continued From page 3 practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to determine if the practice of self-administration of medications was safe for 1 of 1 resident (R3) in the sample observed self-administering medication. Findings include: R3 was observed to self-administer a nebulizer treatment. The resident lacked a self-administration of medications assessment. A trained medication assistant (TMA)-B was observed at 9:38 a.m. on 3/7/12 to take a vial of DuoNeb (a medication that is used to aid breathing) into R3's room, pour the medication into a nebulizer machine, place the face mask on R3 and start the nebulizer machine. TMA-B informed R3, she (the TMA) would be setting an alarm on her medication cart and when the alarm went off, she would return and remove the mask. An interview at 9:41 a.m. on 3/7/12 with TMA-B, revealed R3 had a history of removing the mask prior to the nebulizer treatment being completed. R3's entry minimum data set (MDS) dated 2/7/12 , indicated R3 required extensive assistance or total dependence with activities of daily living, other than eating and use of electric wheelchair. R3 was independent in those areas. R3 was moderately impaired of cognition. R3's physician orders dated 2/29/12 included	F 176	F176 Corrective Action: 1. Self administration of medication assessment was completed for R3 and MAR updated according to the assessment. Systemic Action: 1. Will ensure all residents who are self administering medication or treatments will have SAM assessment completed and MAR or TAR updated to reflect assessment. 2. Staff will be educated on completing SAM assessments and to ensure MAR/TAR is updated. 3. Audits will be completed by DON/designee on all residents who are self administering medications or treatments and ensure all assessments are completed. 4. Results of audits will be reported in QI meetings quarterly. The QI team will make recommendations for ongoing monitoring. Person responsible: Director of Nursing Compliance Date	April 3,4,5 April5

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F 176	Continued From page 4 DuoNeb Inhalation Solution qid (four times per day). There was no physician order authorizing R3 to self-administer medications. An interview with the director of nursing (DON) at 9:57 a.m. on 3/7/12 was completed. The DON verified that R3 was self-administering the nebulizer and an assessment should be done prior to doing so. The DON verified that an assessment had not been done. The facility's policy, dated 2/10, indicated the facility is to assess any resident who wishes to self-administer medication to ensure the resident is safe to do so. The policy also directed staff document on the medication record (MAR) or the treatment record (TAR) if the resident is able to self-administer medication. There was no documentation on the MAR or TAR for R3 to self administer medications.	F 176		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's	F 280	F280 RHS reviews and revises the Care Plan to include all current interventions to maintain/improve ROM Corrective Action: 1. R3 continued in therapy until 3/8/12 when was discharged with Rstv LE ROM program that had been started on 2/27/12. The LE Splint program was never set up as the splints were discontinued D/T the resident's refusal to wear during therapy treatment. R3's Care Plan was updated with current Rstv therapy on 3/8/12 when discharged from Skilled Therapy. This deficiency is currently in the IDR process. 2. An in-service will be given to all nursing staff on updating care plans to reflect resident's current plan of care. Systemic Action: 1. Care plans of residents with special braces/splints will be reviewed to ensure care plan is accurately reflecting current plan of care. 2. Nursing staff will complete periodic audits weekly x 4 then monthly. 3. Results of audits will be reported in QI meetings quarterly. The QI team will make recommendations for ongoing monitoring. 4. Person Responsible: DON Compliance date	April 3,4,5 April 5

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F 280	Continued From page 5 legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to review and revise the care plan to include all current interventions and treatments to maintain/improve range of motion and prevent contractures 1 of 2 residents (R3) reviewed in the sample. Findings include: Resident 3 (R3) did not have current interventions for leg positioning splint use identified in the care plan. A functional maintenance plan for their use was not developed or added to the care plan. R3 had diagnoses that included previous cerebrovascular accident with left side hemiparesis, diabetes mellitus, obesity, anxiety, depression, current pressure ulcer on buttocks, and left tibial fracture 8/2010. The most recent quarterly minimum data set (MDS) dated 1/4/12 identified R3 as cognitively independent (brief interview mental status BIMS=13), with several indicators of mood disorder and totally dependent on two or more staff for bed mobility and transfers. Neither this MDS, nor the admission MDS dated 7/20/11, the quarterly MDS dated 10/12/11 and a discharge MDS dated 2/4/12 at the time of a hospitalization, correctly identified R3 with an impairment in	F 280		

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F 280	Continued From page 6 functional range of motion on the left side extremities. Physical therapy plan of care dated 12/28/11 and progress notes dated 2/8/12 identified R3 with left hand contracture, the left knee lacked 20 degrees of extension and R3 used lower extremity positioning boots to affect joint misalignment and discomfort and prevent external rotation contracture formation. R3's current care plan dated 1/12/12 noted the focus area of restorative nursing was to maintain range of motion and included interventions for range of motion exercise to extremities six (6) days/week and after range of motion was completed to the left hand, application of a blue hand splint that was to be removed after supper or as tolerated. Neither the care plan nor the nursing assistant "To Do List Report" care sheet identified the use or schedule for use of the lower extremity positioning boots. Additionally, use of a left leg ankle foot orthosis (AFO) was not identified in the care plan. The unit registered nurse(RN)-A verified at 9:15 a.m. on 3/7/12, R3 should have a functional maintenance plan in the record and on the care plan that identified use of the positioning boots; however, could not locate one. RN-A also verified the photo on the closet did not include a wear schedule or other approaches or alternatives to use for refusals of the splint.	F 280		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 318		

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F 318	Continued From page 7 with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide/document completion of all treatments and services to maintain/improve range of motion and prevent contractures for 1 of 2 residents (R3) in the sample. Findings include: R3 did not have current interventions for leg positioning splint use, identified in the care plan and a functional maintenance plan for their use was not developed. Not all staff were trained in use of the splints and/or were not aware of a schedule for wear. Additionally, R3 frequently refused to wear the splints; however, other alternatives or approaches to maintain proper positioning of the legs were not evaluated or attempted. R3 had diagnoses that included previous cerebrovascular accident with left side hemiparesis, diabetes mellitus, obesity, anxiety, depression, current pressure ulcer on buttocks, and left tibial fracture 8/2010. The most recent quarterly minimum data set (MDS) dated 1/4/12, identified R3 as cognitively independent (brief interview mental status	F 318	F318 RHS ensures that residents with limited range of motion receive appropriate treatment and services to increase ROM and/or prevent further decrease in ROM. R3 continued in therapy until 3/8/12 when was discharged with Rstv LE ROM program that had been started on 2/27/12. The LE Splint program was never set up as the splints were discontinued D/T the resident's refusal to wear during therapy treatment. R3's Care Plan was updated with current Rstv therapy on 3/8/12 when when discharged from Skilled Therapy. This deficiency is currently in the IDR process. Corrective Action 1. ROM programs for residents receiving ROM will be reviewed to ensure it is getting documented according to program. 2. Nursing staff will complete periodic audits weekly x4 then monthly. 3. Results of audits will be reported in QI meetings quarterly. The QI team will make recommendations for ongoing monitoring. 4. Person responsible: DON Compliance date:	April 5

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F 318	Continued From page 8 BIMS=13), with several indicators of mood disorder and was totally dependent on two or more staff for bed mobility and transfers. Neither this MDS, nor the admission MDS (dated 7/20/11), the quarterly MDS (dated 10/12/11) and a discharge MDS (dated 2/4/12) at the time of a hospitalization, correctly identified R3 with an impairment in functional range of motion on the left side extremities. Physical therapy (PT) plan of care, dated 12/28/11, and progress notes, dated 2/8/12, identified R3 with left hand contracture, the left knee lacked 20 degrees of extension and R3 used lower extremity positioning boots to affect joint misalignment and discomfort and prevent external rotation contracture formation. The PT goals for the plan of care included, [PT] to develop and train caregivers on an appropriate lower extremity nursing program by 2/29/12 and "The patient will tolerate lower extremity positioning boots to achieve effective positioning in bed by 3/8/12." A PT note,dated 2/10/12, identified the comment made by R3, "I don't like the braces (AFOs), too hot on my feet." R3's current care plan, dated 1/12/12, noted the focus area of restorative nursing to maintain range of motion and included interventions for range of motion exercise to extremities 6 days/week and after range of motion was completed to the left hand, application of a blue hand splint that was to be removed after supper or as tolerated. Neither the care plan nor the nursing assistant "To Do List Report" care sheet	F 318		

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	245554	A. BUILDING _____ B. WING _____	03/08/2012

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F 318	Continued From page 9 identified the use or schedule for use of the lower extremity positioning boots. Observations of R3 during the survey noted the positioning boots always located on the window shelf, not applied to R3. A photo of the boot application process was located on the closet door. There was no schedule for wear posted in the room. The physical therapist reported during interview at 3:00 p.m. on 3/6/12, he was not sure what the wear schedule of the leg positioning splints were and thought there was a functional maintenance plan on their use. The PT also stated, "He (R3) hates them, we started having nursing put them on him but the program won't be complete until we discharge him from PT." R3 reported during interview at 7:45 a.m. on 3/7/12, he did not wear the leg splints at all the previous night, "I don't like them and don't wear them any more; at least I'm honest." Nursing assistant(NA)-C, who had worked the night of 3/7/12, stated at 9:12 a.m. the leg splint use should be on the aides "To Do List"; however, was not. NA-C added, " I have never been shown how to put them on, sometimes he wears them, sometimes he doesn't. If he refuses, we tell the nurse and she charts it." The unit registered nurse (RN)-A verified at 9:15 a.m. on 3/7/12, R3 should have a functional maintenance plan in the record and on the care plan that identified use of the positioning boots; however, could not locate one. RN-A also verified the photo on the closet did not include a wear	F 318		

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F 318	Continued From page 10 schedule or other approaches or alternatives to use for refusals of the splint and it was nursing staff, not physical therapy or restorative nursing, that was expected to apply the positioning splints on a daily basis. At 11:05 a.m. on 3/7/12, RN-A reported she had not yet located a functional maintenance plan for the leg splint use and stated, "I'm still working on it."	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistive devices to prevent accidents for 4 of 5 residents (R8, R19, R20, R3) in the sample who utilized anti roll wheelchair brake devices. Findings include: R8, R19, R20 and R3 utilized anti roll (Safe*t Mate) wheelchair brake devices that were not properly adjusted to prevent the wheelchair from	F 323	F323 Corrective Action: 1. Auto lock brakes were fixed for R8, R19, R20, and R39 on 3/7/12. Systemic Action: 1. All residents with auto lock brakes on w/c will have w/c assessed for properly working brakes. 2. Staff will be educated on the use of auto lock brakes and the importance of monitoring and reporting immediately any concerns regarding the proper maintenance. 3. Audits will be completed on residents who have auto lock brakes x4 then monthly to ensure they are working properly. 4. Results of audits will be reported in QI meetings quarterly. The QI team will make recommendations for ongoing monitoring. Person responsible: Director of Nursing Compliance date:	April 3,4,5 April 5

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F 323	Continued From page 11 rolling backwards when the residents attempted to self transfer to/from the wheelchair. R8 had diagnoses that included diabetes mellitus, cerebrovascular accident (CVA) with hemiparesis, and recent fall history. The most recent annual minimum data set (MDS) dated 12/7/11, identified R8 with severe cognitive impairment (brief interview mental status BIMS=1) and extensive assistance of one staff for transfers. R8 had a fall history during self transfer to/from wheelchair on 12/12/11 and the fall risk assessment, dated 3/2/12, identified R8 at high risk for falls. Equipment needs on the assessment did not indicate use of anti roll wheelchair brakes; however, information from the post fall review noted these devices were applied as an intervention after the fall on 12/12/11. The anti roll brakes were noted during the environmental tour at 1:30 p.m. on 3/7/12 to not function properly when the resident was out of the wheelchair. The malfunction was verified by the maintenance director during the tour. R19 had diagnoses that included heart failure and CVA history. The quarterly MDS, dated 2/2/12, identified R19 with moderately impaired cognitive skills (BIMS=12), required supervision for transfers and balance was not steady during transitions. R19 did have a history of falls at the time of admission to the facility but had not fallen in the past six months. R19 was noted to have a wheelchair with anti roll	F 323		

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F 323	Continued From page 12 brakes applied. The functional status of the anti roll brakes was reviewed during the environmental tour at 1:30 p.m. on 3/7/12. The anti roll brakes did not function properly when the resident was out of the wheelchair. The malfunction was verified by the maintenance director during the tour. R20 had diagnoses that included hypertension, diabetes mellitus and dementia. The quarterly MDS, dated 12/14/11, identified R20 with severe cognitive impairment (BIMS=6), extensive assistance for transfers and balance was not steady during transitions. R20 did not have a fall history within the past six months. R20 was noted to have a wheelchair with anti roll brakes applied. The functional status of the anti roll brakes was reviewed during the environmental tour at 1:30 p.m. on 3/7/12. The anti roll brakes did not function properly on the left wheel when the resident was out of the wheelchair and it could roll and turn when weight was applied. The malfunction was verified by the maintenance director during the tour. R39 had diagnoses that included diabetes mellitus and atrial fibrillation. The quarterly MDS, dated 1/23/12, identified R39 with severe cognitive impairment (BIMS=4), extensive assistance of one staff for transfers and balance not steady during transitions. R39	F 323		

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F 323	Continued From page 13 did not have a fall history within the past six months. R39 was noted to have a wheelchair with anti roll brakes applied. The anti roll brakes did not function properly on the right rear wheel. Following the environmental tour on 3/7/12, the maintenance director verified the chair did not function properly on the right rear wheel when the resident was out of the wheelchair and it could roll and turn when weight was applied. The maintenance director verified during interview during the environmental tour on 3/7/12, therapy generally took care of the wheelchairs and stated, "If it's a brake issue, I put on the anti roll brakes, they work pretty well and once in a while don't work and therapy will let me know and I will fix it right away." The maintenance director also verified there were both older and newer styles of anti roll brakes made by Safe*t mate. He indicated he was not aware the anti roll brakes were not properly adjusted for R8, R19, R20 and R39 and had not received any requests from nursing to fix them. The malfunctioning anti roll brakes included both the older and the newer designs. The maintenance director was not aware of any training provided for the direct care staff on how the anti roll brakes functioned and when a referral should be made to maintenance. The Safe*t Mate manufacturer's manual dated 2004 noted, "The anti rollback device should be inspected periodically to ensure that all the mounting hardware is securely tightened and the brake arms are in proper adjustment."	F 323		

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F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure posted nurse staffing data included all specified information, related to total	F 356	F356 Corrective Action: 1. Daily posted nursing schedule format was updated on 3/30/12 to reflect the total number and actual hours worked according to discipline. 2. An in-service will be given to all nursing staff. Systemic Action: 1. DON/designee will complete periodic audits weekly x4 to ensure it is updated in a timely manner. 2. Results of audits will be reported in QI meetings quarterly. The QI team will make recommendations for ongoing monitoring. 3. Person Responsible: DON Compliance date:	April 3, 4, 5 April 5

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F 356	Continued From page 15 and actual hours worked by required category. This had the potential to effect 46 of 46 residents who resided in the facility. Findings include: Review of the facility's posted Daily Nursing Schedules, dated 3/5/12 and 3/6/12, revealed the nurse staffing data lacked identification of the total number and actual hours worked by category of licensed and unlicensed nursing staff, including registered nurses, licensed practical nurses and nurse's aides. The posting instead identified each individual scheduled shift time, categorized by day/evening/night shift, location within the facility and "team" number or employee title. The posting also included the first names of employees who were scheduled for each individual shift time. During interview at 2:10 p.m. on 3/6/12, health unit coordinator (HUC)-A verified she was responsible for posting the facility's nurse staffing data. HUC-A reported that she did not realize the facility's format for posted nurse staffing data did not meet regulation.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure store, prepare, distribute and serve food under sanitary conditions. This had the potential to affect 46 of 46 residents in the facility. Findings include: The facility did not date food items stored in the refrigerator, record temperatures of refrigerators on both the north and south dining rooms, ensure the cleanliness of the north kitchenette and serve/distribute food to residents in a sanitary manner. During initial tour at 1:45 p.m. on 3/5/12, undated food items were observed in the refrigerator, located in the South dining room. Sliced cheese was noted to be in an unlabeled, undated Ziploc bag in the refrigerator door. Two open, half-full maple syrup bottles were also located in the refrigerator door and were noted to be undated. A temperature log, dated 3/12 was taped to the outside of the refrigerator door. The temperature log lacked records of refrigerator temperatures for 3/1/12 through 3/5/12. The temperature at the time of observation was noted as 40 degrees Fahrenheit (F). During interview at 5:40 p.m. on 3/5/12, the director of dietary (DD) reported that a family member must have brought the sliced cheese into the facility and put it in the facility's	F 371	F371 Corrective Action: 1. All undated, unlabeled foods thrown away. Refrigerators were cleaned, housekeeping duties performed. All temperatures taken and logged. 2. All Policy and Procedures were reviewed on labeling, proper hand washing, dating of foods. 3. An in-service will be given to all dietary staff. Systemic Action: 1. Dietary staff will complete audits of refrigerator temp logs daily x2 weeks and monthly thereafter. Audits of refrigerator cleanliness and labeling of food items will be completed by dietary staff 2x week x4, then weekly x4, and monthly thereafter. 2. Staff will be re-educated on an ongoing basis as needed based on the results of the audits. 3. Results of audits will be reported in QI meetings quarterly. The QI team will make recommendations for ongoing monitoring. 4. Staff Responsible: Director of Dietary Compliance date:	April 4 April 5

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F 371	Continued From page 17 refrigerator. DD added, "We don't even have that kind of cheese here." DD verified that the syrup bottles should have been dated with the date they were opened. DD verified the refrigerator temperatures were not being checked and recorded daily, as per the facility's policy. DD reported that the dietary aides were responsible for checking the refrigerators on a daily basis to ensure food items were stored or disposed of as appropriate. DD added, dietary aides were also responsible for checking and recording the refrigerator temperatures on a daily basis. Review of the facility's Food Labeling Policy and Procedure, dated 7/1/11, revealed that all foods needed to have a label and date on the container that was to be stored in the cooler or freezer. All packages/boxes needed to be labeled, identifying what was inside and the date opened. The policy added that any open container without an opened date on it would be thrown away immediately. Review of the facility's undated policy for Record of Refrigeration Temperatures, revealed that the dietary manager was to assign an employee to record all refrigerator and freezer temperatures on a daily basis. At 4:22 p.m. on 3/5/12, the north kitchenette was toured. The refrigerator in the kitchenette had spilled juice/milk and a sticky substance on the shelves. A large dried brown substance was also observed on the floor of the base of the sink cabinet. The floor in the corner of the kitchenette under a wheeled dietary cart had a large amount of dried food debris. At 7:15 a.m. on 3/7/12, the debris beneath the wheeled food cart and the spilled juice/milk and	F 371		

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F 371	Continued From page 18	F 371		

the sticky substance on the shelves of the refrigerator was still present. An interview with dietary aide (DA)-C was completed. DA-C verified the spills in the refrigerator and the large food debris under the dietary cart. DA-C reported the dietary staff are responsible to spot clean the refrigerator, whenever they put food items into it. DA-C thought that the housekeeping staff was responsible for cleaning everything else in the kitchenette.

At 7:55 a.m. on 3/7/12, an interview with the dietary manager (DM) was completed. DM verified the interior of the refrigerator was not clean and had milk/juice spills and a sticky substance on the shelf. DM reported that the dietary staff is to ensure the cleanliness of the interior of the kitchen. DM reported she had talked to the dietary staff and discovered that the spot cleaning had not been done the past two days. DM also reported that no schedule was in place for deep cleaning of the refrigerator by the dietary staff. DM indicated the housekeeping staff is responsible for cleaning everything in the kitchenette, other than the interior of the refrigerator. DM verified that floor by wheeled food cart had significant debris build up and the base of the cabinet under the sink was dirty.

At 11:44 a.m. 3/7/12, an interview with housekeeping staff (HS)-A was completed. HS-A reported she was responsible for the cleanliness of the kitchenette on the north wing. She reported she cleaned the floor daily, generally after the noon meal. HS-A verified the build up of debris on the floor. HS-A attempted to remove the wheeled cart from the kitchenette but was unable to do so. After HS-A was unable to remove the

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F 371	Continued From page 19 wheeled cart from the kitchenette, she attempted to clean under the cart with a broom. The broom did not reach all the debris under and surrounding the cart in the alcove. During the evening meal of 3/5/12 on the Centennial unit, several staff were noted to serve food without disinfecting/washing hands between serving multiple residents and after touching the residents, furniture and ready to serve/eat food items. The evening supper meal observation beginning at 5:25 p.m. on 3/5/12 included ham salad on a bun, sandwich, soup, coleslaw and french fries. Observation of dietary staff-A (DA-A) who served the meal revealed use of gloves; however, during the course of serving the meal, DA-A was noted to touch shelving, her clothing items and other nearby surfaces and then used the gloved fingers to remove the ham salad on to the plate for residents who did not want a bun. No utensils were used to scrape the ham salad off the buns. In addition, nursing assistants (NA) -A, and C were observed to deliver food to each resident seated at the tables without washing or disinfecting hands between the contacts. During the delivery process, NA-A and NA-C were noted to touch residents, resident's clothing, their own clothing, furniture items and other surfaces as well as bare hand contact with the burger buns and sandwiches. Upon returning to the serving area, no hand washing or alcohol based disinfection was observed. NA-A was also observed to deliver food to resident's rooms without disinfection noted before serving others.	F 371		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=D	Continued From page 20 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F441 Corrective Action: 1. The electric razor with buildup was cleaned on 3/5/12 and all other razors in the tub rooms were checked and found to be clean of any debris.. 2. Policy on cleaning razors was reviewed and updated. 3. An in-service will be given to all nursing staff. Systemic Action: 1. Nursing staff will complete audits weekly x4 then monthly to ensure infection control practices are met. 2. Results of audits will be reported in QI meetings quarterly. The QI team will make recommendations for ongoing monitoring. 3. Person Responsible: DON Compliance date:	April 3,4,5 April 5

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infections (use and cleaning of community electric razors) in one of four bathing rooms. This practice had the potential to affect four residents in the facility. Finding include: At 3:15 p.m. on 3/5/12, three electric razors were observed on a table in the tub room on the north wing of the facility. One of the electric razors had a significant build up of hair in the head of the razor. An interview with nursing assistant (NA)-E was completed at 3:15 p.m. on 3/5/12. NA-E reported the community razor is used on most of the resident but a few residents have their own razors. NA-E reported the razors were to be cleaned after each resident use, but was unsure of the procedure to do so. NA-E verified the significant build up of hair and described the condition of the head of the razor as "gross." At 4:56 p.m. on 3/5/12, an interview with the director of nursing (DON) was completed. The DON reported that she believed most of the residents at the facility had their own razors. The DON indicated if a community razor is used, the razor is to be cleaned with alcohol between each resident use. The DON verified the presence of the three community razors in the north tub room and also indicated that the debris build up on one	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING _____ B. WING _____	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 22 of the razors was not acceptable and needed to be cleaned. The facility policy and procedure labeled "Cleaning Razors", dated 11/09, was received. The policy indicated the facility was to "make sure resident razors and facility razors are cleaned and disinfected to prevent spread of infection." The procedure for cleaning facility razors directed staff, after each resident use to open the top of the razor and clean off excess hair from inside the razor with razor brush. Staff were then instructed to wipe off the outside of the razor with alcohol pad and allow to dry. This was not followed.	F 441		

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Tuesday, April 10, 2012 3:29 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: Shellum, George (DPS); 'jingersoll@renvilla.sfhs.org'; 'Colleen Leach'; 'Jim Loveland'; Leppke, Susan (MDH); 'Mark Meath'; 'Mary Henderson'; 'Shellae Dietrich'; Steege, Nicole (MDH); Whitney, Marian (DPS)
Subject: Renvilla Health Center (245554) FSES Evaluation Report

This is to inform you that I am accepting the FSES that was conducted on 11-7-11 for Renvilla Health Center. The exit date was 3-8-12.

I am accepting this FSES because it was completed approximately 4 months ago, and because the Administrator has stated that conditions in the facility have not changed since the FSES was completed.

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

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

F5554020

PRINTED: 03/21/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety on March 13, 2012. At the time of this survey, Building 01 of Renvilla Health 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 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 ST. Paul, MN 55101-5145	K 000	POC ok W/FSES for K72 PS 4-10-12 RECEIVED APR - 5 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Exit: 3-8-12 DC: 4-17-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	4-3-12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Pat.Sheehan@state.mn.us Facsimile: 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Renvilla Health Center was constructed as follows: The original building was built in 1963, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was built in 1970, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was built in 1993, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors which is monitored for automatic fire department notification. The facility has a capacity of 46 beds and had a census of 40 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

(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 2 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 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with NFPA 70 National Electrical Code (1999 edition) and NFPA 72 National Fire Alarm Code (1999 edition). The system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70 (99) and NFPA 72 (99) and NFPA 101 Life Safety Code (2000 edition), Chapter 9, Section 9.6.1.4. FINDINGS INCLUDE: On 3/13/12 between 11:30 AM and 2:30 PM, during a review of available documentation provided by facility staff, it was confirmed the facility's Digital Alarm Communicator Transmitter (DACT) was not tested during the months of March, June, September and December of 2011. The DACT must be tested monthly in accordance with CMS policy, as provided for at NFPA 72 (99)	K 052	K052 Corrective Action: 1. Review policy for fire drills including DACT. 2. Fire drills will be conducted quarterly on each shift. Systemic Action: 1. Environmental Services Director to monitor fire drills and frequency. 2. Fire drill audits will be reported in QI meetings quarterly. The QI team will make recommendations for ongoing monitoring.	3/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

(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 3 Chapter 7, Section 7-3.2. In a fire emergency, this deficient practice could adversely affect 46 of 46 residents, staff and visitors.	K 052		
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - Cooking facilities shall be protected and maintained in accordance with NFPA 101 (2000), Chapter 19, Section 19.3.2.6 and Chapter 9, Section 9.2.3. and NFPA 96 (1998). This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility prepared French toast on a portable griddle outside of the main dietary kitchen, using a vegetable oil spray which creates grease-laden vapors. These cooking operations were not protected by a Type-I range hood with a UL-300 automatic fire extinguishment system. In a fire emergency, this deficient practice could adversely affect 30 of 30 residents, staff and visitors within the involved smoke compartment. FINDINGS INCLUDE: On 3/7/12 at 7:15 AM, a Minnesota Department of Health [MDH] surveyor observed facility staff preparing French toast for residents, using a portable griddle located in the Centennial Dining	K 069	K069 Corrective Action: 1. Vegetable oil spray was immediately removed from the area 2. Dietary employees reviewed regulation Systemic Action: 1. Audits will be reported in QI meetings quarterly. The QI team will make recommendations for ongoing monitoring. 2. Environmental Services Director is responsible for the correction of this deficiency	3/17/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

(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 069	Continued From page 4 Room. This cooking operation involved the use of a vegetable oil spray to coat the surface of the griddle. Further investigation and an interview with the dietary manager confirmed this practice. When used to coat the surface of a griddle or frying pan, vegetable oil spray is a product which can create grease-laden vapors, and these cooking operations require protection by a Type-I range hood with a UL-300 automatic fire extinguishment system, in accordance with NFPA 96 (1998 edition) and MDH Policy.	K 069		
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: NFPA 101 [2000] LIFE SAFETY CODE SURVEY REGULATION - Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof and shall be in accordance with NFPA 101 [00] Chapter 19, Section 19.2.3.3 and Chapter 7, Sections 7.1.10 and 7.3.2. This STANDARD is not met as evidenced by: Based on observations, the facility has corridor	K 072	K072 Corrective Action: 1. A Fire Safety Evaluation System (FSES) was completed on 11/07/11. We are in compliance as of 12/02/11 as a result of the FSES. There have been no changes since that would have affected the RenVilla from a LSC standpoint. Systemic Action: 1. The Administrator is responsible for the correction of the deficiency.	FSES 4-3-12 ~~12/2/11~~

U:\Jim\MDH\2012 Survey\State Fire Marshal\KTag 072 Plan of Correction - 03 2012.docx

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

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K 072	Continued From page 5 obstructions. These obstructions could interfere with the convenient and effective removal of residents, staff and visitors in an emergency situation. FINDINGS INCLUDE: On 3/13/12 between 11:30 AM and 2:30 PM, it was observed that: A). Interior finish materials mounted on corridor walls in the 100 Wing and 200 Wing have diminished the width of these existing corridors. The original corridor width of 82 1/4-inches has been reduced at various points along the entire length of the corridors by as little as one-inch [between the aluminum siding on one side to the lap siding on the opposite side) to as much as 5 1/4-inches [between the faux tree trunk on one side to the frame of the faux window on the other side].; B). Grab rails mounted on corridor walls of the 100 Wing and 200 Wing project between 5-inches and 5 1/2-inches into the corridors, as measured from the original gypsum wall board to the outside edges of the wooden rails. **NOTE** This K-Tag will not need to be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code, 2000 edition.	K 072		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING 02 - 2008 RESIDENT WING AD B. WING _____	03/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety on March 3, 2012. At the time of this survey, Building 02 of Renvilla Health 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 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 ST. Paul, MN 55101-5145	K 000	poc ok PS 4-10-12 RECEIVED APR - 5 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

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

Administrator | 4-3-12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING 02 - 2008 RESIDENT WING AD B. WING _____	03/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Pat.Sheehan@state.mn.us Facsimile: 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 02 of Renvilla Health Center consists of the 2008 resident wing addition. It is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. All resident rooms are equipped with automatic, interconnected smoke detectors as well. The facility has a capacity of 46 beds and had a census of 40 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=F	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	K 052		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING 02 - 2008 RESIDENT WING AD B. WING _____	03/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

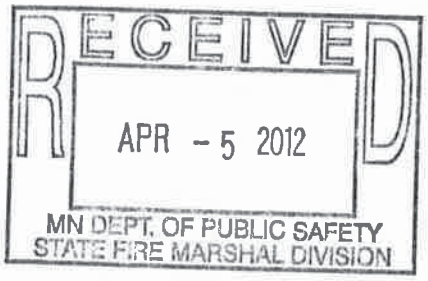
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 2 and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with NFPA 70 National Electrical Code (1999 edition) and NFPA 72 National Fire Alarm Code (1999 edition). The system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70 (99) and NFPA 72 (99) and NFPA 101 Life Safety Code (2000 edition), Chapter 9, Section 9.6.1.4. FINDINGS INCLUDE: On 3/13/12 between 11:30 AM and 2:30 PM, during a review of available documentation provided by facility staff, it was confirmed the facility's Digital Alarm Communicator Transmitter (DACT) was not tested during the months of March, June, September and December of 2011. The DACT must be tested monthly in accordance with CMS policy, as provided for at NFPA 72 (99) Chapter 7, Section 7-3.2. In a fire emergency, this deficient practice could adversely affect 46 of 46 residents, staff and visitors.	K 052	K052 Corrective Action: 1. Review policy for fire drills including DACT. 2. Fire drills will be conducted quarterly on each shift. Systemic Action: 1. Environmental Services Director to monitor fire drills and frequency. 2. Fire drill audits will be reported in QI meetings quarterly. The QI team will make recommendations for ongoing monitoring.	3/17/12

U:\Jim\MDH\2012 Survey\State Fire Marshal\KTag 052 Plan of Correction - 03-2012.docx

Report of Consultant FSES Findings

Renvilla Health Center

Date of Survey: November 7, 2011



Prepared by:
Robert L. Imholte, President
Fire Safety Resources, LLC
16768 County Road 160
Cold Spring, MN 56320
320-685-8559
RImholteFiresafe@aol.com

Fire Safety Resources, LLC
Consulting, Education & Inspection Services

16768 County Road 160
Cold Spring, MN 56320
(320) 685-8559
E-mail: RImholteFiresafe@aol.com

November 17, 2011

Mr. James Ingersoll
Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, Minnesota 56284

RE: FSES at Renvilla Health Center

Dear Mr. Ingersoll:

Enclosed please find the survey information relating to the fire safety evaluation of Renvilla Health Center, 205 Southeast Elm Avenue in Renville conducted on 11/07/11. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*.

As you're aware, the FSES is a rating system designed to evaluate the level of fire/life safety in health care facilities and serves as a method to demonstrate alternative compliance with the 2000 edition of the *Life Safety Code*® (NFPA 101). An FSES was made necessary in this case because of a corridor obstruction (K072) deficiency cited during a state fire/life safety recertification survey conducted on 02/18/11.

According to the Statement of Deficiencies from the 02/18/11 fire/life safety recertification survey, Renvilla Health Center was surveyed as two buildings: Building 01 – Main Building (consisting of the 1963 original building and 1970 and 1993 additions) and Building 02 (2008 addition). Buildings 01 and 02 are separated by construction having a fire resistance rating of at least 2 hours. Because the deficiency that triggered the FSES was cited in Building 01 (Main Building), this FSES covers that building only.

The following factors served as the basis for this evaluation:

- Because Building 01 and its additions were constructed prior to 03/11/03, Renvilla Health Center was considered an existing building.
- Renvilla Health Center is one story in height and has a partial basement. For purposes of this FSES, the two building levels were divided into five (5) separate smoke zones.
- For purposes of this FSES, it was assumed that the basement level does not involve resident housing, treatment or customary access.

Initial calculations show that Renvilla Health Center does **not** pass the FSES in its current state. What follows is a series of recommendations that should help the facility achieve a passing FSES score.

In accordance with NFPA 101A(01), Sec. 4.2.3, a building must be able to meet all the requirements listed in Table 8, FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET, in order to successfully pass the FSES. In other words, instead of being assigned a score, these conditions are pass-fail. Because of conditions found at Renvilla Health Center on 11/07/11, Item A in Table 8 was identified as 'Not Met' based on the following:

> A newly installed air conditioning unit in the food storage room located off of the kitchen on main level was found to be supplied by extension cord wiring instead of fixed wiring installed in conformance with the Electrical Code.

This issue must be properly addressed in order for Renvilla Health Center to meet the requirements of NFPA 101(00), Sections 19.5.1 and 9.1.1 and pass the FSES.

Another condition of successfully passing the FSES is that a building must be able to achieve a score of zero (0) or better in all zones evaluated and in all four of the following categories in Table 7 of the FSES worksheets (Form CMS-2786T), ZONE FIRE SAFETY EQUIVALENCY EVALUATION:

- Containment Safety,
- Extinguishment Safety,
- People Movement Safety, and
- General Safety.

Based on conditions found during the on-site visit to the facility on 11/07/11, calculations show negative scores in one or more of these categories in three of the five zones evaluated. This occurred because of the following factors:

1. Pursuant to language in NFPA 101A(01), Sec. 4.4, no credit could be given for the building fire sprinkler system, as it was found not to be installed and maintained in accordance with NFPA 101(00), Sections 19.3.5 and 9.7. As a result, a score of 0 was assigned to Parameter 13, *Automatic Sprinklers*, in each of the five zones evaluated. This score was assigned due to the following conditions found on 11/07/11:
   a. The escutcheon plate was found to be missing from a pendent spray sprinkler head in the food storage room located off of the kitchen. This does not meet the requirements of NFPA 13(99), Sections 3-2.7 and 5-3.1.1.
   b. Paint was found on a sprinkler head located near the restroom in the basement Break Room, which does not meet the requirements of NFPA 13(99), Sec. 3-2.6.3 and NFPA 25(98), Sec. 2-2.1.1.
   c. It was observed that the deflector on one of the upright sprinkler heads in the basement Storage Room was damaged so that it was not aligned parallel with the ceiling as required by NFPA 13(99), Sec. 5-6.4.2.
   d. Network cable was found attached to the sprinkler piping in the basement Break Room, which does not meet the requirements of NFPA 25(98), Sec. 2-2.2.
   e. It was found that the restroom located off of the basement Break Room is not protected by fire sprinklers. This does not meet the requirements of NFPA 13(99), Sec. 1-6.1.

2. Multiple unprotected conduit penetrations were found in the wall separating the Storage Room from the basement corridor.
3. An unprotected wiring penetration was observed through the ceiling of the Mechanical Room on the basement level.
4. Four (4) unprotected conduits and wiring and plumbing penetrations were found in the wall between the phone room/storage room and the In-service Room on the basement level.
5. Three (3) unprotected conduit penetrations were found in the wall between Therapy Storage and the In-service Room on the basement level.
6. It was observed that the plain glass door into Human Resources in the 100 Wing on main level is not positive latching, nor is the room protected by automatic smoke detection to meet the exceptions to NFPA 101(00), Sec. 19.3.6.1.

Again, because no credit could be given for the building fire sprinkler system, Item A was indicated as 'Not Met' in Table 8 of the FSES Worksheets, and negative scores were assigned to various safety parameters in Table 4 of the Worksheets, Renvilla Health Center has currently **not** achieved a passing FSES score. It must be noted, however, that a score of zero (0) or better **can** be achieved in all five zones evaluated and in all four of the categories in Table 7 of the FSES worksheets provided that, at a minimum, the following corrections are made:

1. If the openings found around the conduit penetrations of the wall separating the Storage Room from the basement corridor were sealed with a listed through-penetration fire-stop system providing a fire resistance equal to that of the existing wall, the score for Parameter 4, *Corridor Partitions/Walls*, in Table 4 of the FSES worksheets for Zone 1 (Basement) would change from -10 to +2 and the score for Parameter 5, *Doors to Corridor*, in Table 4 of the FSES worksheets for Zone 1 (Basement) would change from 0 to +1.
2. If the corridor door into Human Resources in the 100 Wing on main level were equipped with positive latching hardware, the score for Parameter 5, *Doors to Corridor*, in Table 4 of the FSES worksheets for Zone 3 (Main Level 100/200/300 Wings) would change from -10 to 0. As an alternate, if the room were protected by automatic smoke detection to meet the exceptions to NFPA 101(00), Sec. 19.3.6.1, the score for this Parameter would change from -10 to +1.
3. If the openings found around wiring penetrating the ceiling in the basement Mechanical Room were sealed with a listed through-penetration fire-stop system providing a fire resistance equal to that of the existing floor/ceiling assembly, the score for Parameter 7, *Vertical Openings*, in Table 4 of the FSES worksheets for Zone 1 (Basement) would change from -10 to +2 and in the remaining four zones evaluated would change from -10 to 0.
4. If the openings found around the conduit, wiring and plumbing penetrations of the walls at the phone room/storage room and Therapy Storage, both of which open into the In-service Room on the basement level, were sealed with a listed through-penetration fire-stop system providing a fire resistance equal to that of the existing walls, the score for Parameter 8, *Hazardous Areas*, in Table 4 of the FSES worksheets for Zone 1 (Basement) would change from -6 to 0 and the score for Parameter 8, *Hazardous Areas*, in Table 4 of the FSES worksheets for Zone 2 (Main Level Administrative Wing) would change from -2 to 0.
5. If the sprinkler deficiencies identified on page 2 of 4 of this letter are addressed, the score for Parameter 13, *Automatic Sprinklers*, will change from 0 to +10 in all five zones evaluated.

As shown in the Table of Alternates attached to the FSES worksheets for Zones 1 through 5, these scoring changes will result in Renvilla Health Center achieving a passing score of zero (0) or better in all four categories in Table 7 of the FSES worksheets.

Should you have any questions or need additional information, please don't hesitate to get back to me.

Wishing you a safe day!

Robert L. Imholte
President
Fire Safety Resources, LLC

Enclosures

RLI/rli

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

Form Approved
OMB No. 0938-0242

ZONE 1 OF 5 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
RENVILLA HEALTH CENTER	01-MAIN BUILDING
ZONE(S) EVALUATED: BASEMENT	
PROVIDER/VENDOR NO.: 245554	DATE OF SURVEY: 11/07/11

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors Values				
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable
	Risk Factor	1.0	1.6	3.2	4.5
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30
	Risk Factor	1.0	1.2	1.5	2.0
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	1.1	1.2	1.4	1.6	(1.6)
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	1.2	1.5	4.0
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 year		65 Years and Over 1 Year and Younger		
	Risk Factor	1.0		1.2		

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	[ ]	X	[ ]	X	[ ]	X	[ ]	X	[ ]	=	[1.6]

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X	[ ]	=	[ ]

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	[1.6]	=	[1.0]

* **FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR SIGNATURE	TITLE	DATE
Robert J. Smith – FIRE SAFETY RESOURCES, LLC	PRESIDENT	11/16/11
FIRE AUTHORITY SIGNATURE: Fire Safety Supervisor	TITLE: State Fire Marshal	DATE: 4-10-12

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	2	2		2
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	-10			-10
5. Doors to Corridor	0		0	0
6. Zone Dimensions			1	1
7. Vertical Openings	-10		-10	-10
8. Hazardous Areas	-6	-6		-6
9. Smoke Control			0	0
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		0	0	0
13. Automatic Sprinklers	0	0	÷ 2 = 0	0
Total Value	S_1= -18	S_2= -2	S_3= -6	S_4= -15

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	11	5	15(12)[a]	4	8(5)[a]	1
2nd or 3rd story[b]	15	(9)	17(14)[a]	(6)	10(7)[a]	(3)
4th story or higher	18	9	19(16)[a]	6	11(8)[a]	3

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Table 5 Alternate Facility RENVILLA HEALTH CENTER - #245554 Zone #1 - BASEMENT Date: 11/07/11

Safety Parameters	As Is				Alt. 1				Alt. 2				Alt. 3			
	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)
1. Construction	2	2		2	2	2		2								
2. Interior Finish (Corr.& Exit)	3		3	3	3		3	3								
3. Interior Finish (Rooms)	3			3	3			3								
4. Corridor Partitions/Walls	-10			-10	2			2								
5. Doors to Corridor	0		0	0	1		1	1								
6. Zone Dimensions			1	1			1	1								
7. Vertical Openings	-10		-10	-10	2		2	2								
8. Hazardous Areas	-6	-6		-6	0	0		0								
9. Smoke Control			0	0			0	0								
10. Emergency Movement Routes			0	0			0	0								
11. Manual Fire Alarm		2		2		2		2								
12. Smoke Detection & Alarm		0	0	0		0	0	0								
13. Automatic Sprinklers	0	0	0 ½	0	10	10	5 ½	10			½				½	
A. Total Value	-18	-2	-6	-15	23	14	12	26								
B. Mandatory Values	9	6	3	1	9	6	3	1								
C. Difference Between A & B	-27	-8	-9	-16	14	8	9	25								
D. If C is 0 or more, check box					✓	✓	✓	✓								

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

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ZONE 2 OF 5 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
RENVILLA HEALTH CENTER	01-MAIN BUILDING
ZONE(S) EVALUATED: MAIN LEVEL ADMINISTRATINE WING	
PROVIDER/VENDOR NO.: 245554	DATE OF SURVEY: 11/07/11

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable	
	Risk Factor	1.0	1.6	(3.2)	4.5	
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30	
	Risk Factor	1.0	1.2	1.5	(2.0)	
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	(1.1)	1.2	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	(1.2)	1.5	4.0
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 year		65 Years and Over 1 Year and Younger		
	Risk Factor	1.0		(1.2)		

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	2.0	X	1.1	X	1.2	X	1.2	=	10.1

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

F		R
1.0 X		=

TABLE 3B. (EXISTING BUILDINGS)

F		R		
0.6 X	10.1	=	6.1	= 7

*** FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR SIGNATURE: Robert J. Smithette, FIRE SAFETY RESOURCES, LLC	TITLE: PRESIDENT	DATE: 11/16/11
FIRE AUTHORITY SIGNATURE	TITLE: Fire Safety Supervisor / State Fire Marshal	DATE: 4-10-12

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	2	2		2
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	0			0
5. Doors to Corridor	1		1	1
6. Zone Dimensions			-2	-2
7. Vertical Openings	-10		-10	-10
8. Hazardous Areas	-2	-2		-2
9. Smoke Control			0	0
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		2	2	2
13. Automatic Sprinklers	0	0	÷2 = 0	0
Total Value	S_1= -3	S_2= 4	S_3= -6	S_4= -1

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	11	(5)	15(12)[a]	(4)	8(5)[a]	(1)
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher	18	9	19(16)[a]	6	11(8)[a]	3

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Table 5 Alternate Facility RENVILLA HEALTH CENTER - #245554 Zone # 2 Date: 11/07/11

Safety Parameters	As Is				Alt. 1				Alt. 2				Alt. 3			
	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)
1. Construction	2	2		2	2	2		2								
2. Interior Finish (Corr.& Exit)	3		3	3	3		3	3								
3. Interior Finish (Rooms)	3			3	3			3								
4. Corridor Partitions/Walls	0			0	0			0								
5. Doors to Corridor	1		1	1	1		1	1								
6. Zone Dimensions			-2	-2			-2	-2								
7. Vertical Openings	-10		-10	-10	0		0	0								
8. Hazardous Areas	-2	-2		-2	0	0		0								
9. Smoke Control			0	0			0	0								
10. Emergency Movement Routes			0	0			0	0								
11. Manual Fire Alarm		2		2		2		2								
12. Smoke Detection & Alarm		2	2	2		2	2	2								
13. Automatic Sprinklers	0	0	0 ½	0	10	10	5 ½	10			½				½	
A. Total Value	-3	4	-6	-1	19	16	9	21								
B. Mandatory Values	5	4	1	7	5	4	1	7								
C. Difference Between A & B	-8	0	-7	-8	14	12	8	14								
D. If C is 0 or more. check box		✓			✓	✓	✓	✓								

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ZONE 3 OF 5 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
Renville Health Center	01-Main Building
ZONE(S) EVALUATED: Main Level 100/200/300 Wings	
PROVIDER/VENDOR NO.: 245554	DATE OF SURVEY: 11/07/11

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors Values				
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable
	Risk Factor	1.0	1.6	(3.2)	4.5
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30
	Risk Factor	1.0	1.2	(1.5)	2.0
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	(1.1)	1.2	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	1.2	(1.5)	4.0
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 year		65 Years and Over 1 Year and Younger		
	Risk Factor	1.0		(1.2)		

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.5	X	1.1	X	1.5	X	1.2	=	9.5

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R	
0.6 X	9.5	=	5.7	= 6

*** FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR SIGNATURE	TITLE	DATE
Robert J. Kinstle, Fire Safety Resources, LLC	President	11/16/11
FIRE AUTHORITY SIGNATURE	TITLE	DATE
Fire Safety Supervisor	State Fire Marshal	4-10-12

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	2	2		2
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	0			0
5. Doors to Corridor	-10		-10	-10
6. Zone Dimensions			-2	-2
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-2	-2
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		2	2	2
13. Automatic Sprinklers	0	0	÷2 = 0	0
Total Value	S_1= -2	S_2= 6	S_3= -9	S_4= -2

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	11	(5)	15(12)[a]	(4)	8(5)[a]	(1)
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher	18	9	19(16)[a]	6	11(8)[a]	3

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Table 5 Alternate Facility RENVILLA HEALTH CENTER - #245554 Zone # 3 Date: 11/07/11

Safety Parameters	As Is				Alt. 1				Alt. 2				Alt. 3			
	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)	Containment (S_1)	Extinguishment (S_2)	People Movement (S_3)	General Safety (S_G)
1. Construction	2	2		2	2	2		2	2	2		2				
2. Interior Finish (Corr.& Exit)	3		3	3	3		3	3	3		3	3				
3. Interior Finish (Rooms)	3			3	3			3	3			3				
4. Corridor Partitions/Walls	0			0	0			0	0			0				
5. Doors to Corridor	-10		-10	-10	0		0	0	1		1	1				
6. Zone Dimensions			-2	-2			-2	-2			-2	-2				
7. Vertical Openings	0		0	0	0		0	0	0		0	0				
8. Hazardous Areas	0	0		0	0	0		0	0	0		0				
9. Smoke Control			0	0			0	0			0	0				
10. Emergency Movement Routes			-2	-2			-2	-2			-2	-2				
11. Manual Fire Alarm		2		2		2		2		2		2				
12. Smoke Detection & Alarm		2	2	2		2	2	2		2	2	2				
13. Automatic Sprinklers	0	0	0 ½	0	10	10	5 ½	10	10	10	5 ½	10			½	
A. Total Value	-2	6	-9	-2	18	16	6	18	19	16	7	19				
B. Mandatory Values	5	4	1	6	5	4	1	6	5	4	1	6				
C. Difference Between A & B	-7	2	-10	-8	13	12	5	12	14	12	6	13				
D. If C is 0 or more, check box		✓			✓	✓	✓	✓	✓	✓	✓	✓				

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

Form Approved
OMB No. 0938-0242

ZONE 4 OF 5 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
RENVILLA HEALTH CENTER	01-MAIN BUILDING
ZONE(S) EVALUATED: MAIN LEVEL 400 WING	
PROVIDER/VENDOR NO.: 245554	DATE OF SURVEY: 11/07/11

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors Values				
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable
	Risk Factor	1.0	(1.6)	3.2	4.5
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30
	Risk Factor	(1.0)	1.2	1.5	2.0
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	(1.1)	1.2	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	1.2	1.5	(4.0)
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 year		65 Years and Over 1 Year and Younger		
	Risk Factor	1.0		(1.2)		

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	1.6	X	1.0	X	1.1	X	4.0	X	1.2	=	8.4

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

F		R
1.0 X		=

TABLE 3B. (EXISTING BUILDINGS)

F		R
0.6 X	8.4	= 5.0

*** FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR SIGNATURE: Robert L. Sublette – FIRE SAFETY RESOURCES, LLC	TITLE: PRESIDENT	DATE: 11/16/11
FIRE AUTHORITY SIGNATURE	TITLE: Fire Safety Supervisor / State Fire Marshal	DATE: 4-10-12

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	2	2		2
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	2			2
5. Doors to Corridor	1		1	1
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		2	2	2
13. Automatic Sprinklers	0	0	÷ 2 = 0	0
Total Value	S_1= 11	S_2= 6	S_3= 7	S_4= 16

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	11	(5)	15(12)[a]	(4)	8(5)[a]	(1)
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher	18	9	19(16)[a]	6	11(8)[a]	3

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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OMB No. 0938-0242

ZONE 5 OF 5 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
Renvilla Health Center	01- Main Building

ZONE(S) EVALUATED: Main Level 500 Wing

PROVIDER/VENDOR NO.	DATE OF SURVEY
145554	11/07/11

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors Values				
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable
	Risk Factor	1.0	1.6	(3.2)	4.5
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30
	Risk Factor	1.0	(1.2)	1.5	2.0
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	(1.1)	1.2	1.4	1.6	1.6
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0	1.1	1.2	1.5	(4.0)
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 year		65 Years and Over 1 Year and Younger		
	Risk Factor	1.0		(1.2)		

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.2	X	1.1	X	4.0	X	1.2	=	20.3

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R	
0.6 X	20.3	=	12.2	= 13

*** FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR SIGNATURE	TITLE	DATE
Robert J. Smitobie, Fire Safety Resources, LLC	President	11/16/11
FIRE AUTHORITY SIGNATURE	TITLE	DATE
Fire Safety Supervisor	State Fire Marshal	4-10-12

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	2	2		2
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	2			2
5. Doors to Corridor	1		1	1
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			1	1
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		2	2	2
13. Automatic Sprinklers	0	0	÷ 2 = 0	0
Total Value	S_1= 11	S_2= 6	S_3= 8	S_4= 17

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	11	(5)	15(12)[a]	(4)	8(5)[a]	(1)
2nd or 3rd story[b]	15	9	17(14)[a]	6	10(7)[a]	3
4th story or higher	18	9	19(16)[a]	6	11(8)[a]	3

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

FIRE SAFETY EVALUATION

Name of Facility: Renvilla Health Center
Address: 205 Southeast Elm Avenue, Renville, MN 56284
Phone: 320-329-8381
Licensed capacity: 46
Census at time of survey: 43

Evaluator: Robert L. Imholte, President, *Fire Safety Resources, LLC*

What follows is a report on the findings of a fire safety evaluation of the above-named facility that was conducted during an on-site visit to the facility between 0905 hours and 1715 hours on 11/07/11. This evaluation was conducted in accordance with the Fire Safety Evaluation System (FSES) specified in Chapter 4 of NFPA 101A(01), *Guide to Alternative Approaches to Life Safety*. Based on this evaluation, Renvilla Health Center does not achieve a passing score on the FSES.

In addition to the 11/07/11 on-site visit, the findings outlined herein are based on:

- Information provided by Mr. James Ingersoll, Administrator; Mr. Scott Jackson, Director of Projects and Community Services, St. Francis Health Services; and Mr. Michael Becker, Director of Environmental Services; and
- A review of the Statement of Deficiencies (Form CMS-2567) from a fire/life safety recertification survey conducted on 02/18/11.

Initial Comments:
A review of the Statement of Deficiencies from the 02/18/11 fire/life safety recertification survey revealed that Renvilla Health Center was surveyed as two buildings: Building 01 – Main Building, consisting of the 1963 original building and 1970 and 1993 additions, and Building 02, the 2008 resident wing addition. Buildings 01 and 02 are separated by construction having a fire resistance rating of at least 2 hours. Because the deficiency that triggered the FSES was cited in Building 01 (Main Building), this FSES covers that building only.

At the east end of the building's 400 Wing the nursing home is connected to a senior assisted living facility called East Ridge. At the south end of the basement level of the 1970/1993 additions there is a connection to an adjacent senior living building called Meadows on Main. Because neither East Ridge nor Meadows on Main is used for purposes of housing, treatment or customary access by the facility's residents and because both are separated from the nursing home by 2-hour-rated fire barriers, those buildings were not included in this evaluation.

The building's 400 Wing is occupied by five (5) assisted living residents, who are not included in the facility's licensed capacity. This wing is not separated from the nursing home by construction having a fire resistance rating of at least 2 hours. This portion of the building was, therefore, considered part of the nursing home for purposes of this evaluation.

Building 01 (Main Building) was originally constructed in 1963 as a single story building with no basement. In 1970 a one-story addition with a partial basement was added to the south of the original building. In 1993 another single story addition with basement was added to the south of the 1970 addition. It was determined that the original building and two additions were constructed of masonry exterior walls and a precast concrete plank roof deck. Due to the presence of protected steel structural members supporting the roof deck, the original building and two additions were assigned a Type II(111) construction type in accordance with NFPA 220(99), Sec. 3-2 and Table 3-1

Because the original building and two additions were constructed prior to 03/11/03, the facility is considered an existing building for federal certification purposes and was, therefore, treated as such for assigning values on the FSES worksheets.

The facility has a fire alarm system with automatic smoke detection in the main level corridors and spaces open to corridors, which is monitored for automatic fire department notification. Based on documentation review, the fire alarm system is being inspected, tested and maintained in accordance with NFPA 72.

Except as otherwise indicated in this report, the facility is protected throughout by a supervised, wet-pipe automatic fire sprinkler system. A dry-pipe automatic fire sprinkler system, however, protects the administrative area located in the 1970 addition. A review of records revealed that the building's sprinkler system underwent a complete annual check by Building Sprinkler, Inc., on 06/20/11. Pursuant to language in NFPA 101A(01), Sec. 4.4, this fire protection system was given no credit in this evaluation because of the following problems found during this survey:

- The escutcheon plate was found to be missing from a pendent spray sprinkler head in the food storage room located off of the kitchen, which does not meet the requirements of NFPA 13(99), Sections 3-2.7 and 5-3.1.1.
- Paint was found on a sprinkler head located near the restroom in the basement Break Room, which does not meet the requirements of NFPA 13(99), Sec. 3-2.6.3 and NFPA 25(98), Sec. 2-2.1.1.
- It was observed that the deflector on one of the upright sprinkler heads in the basement Storage Room was damaged so that it was not aligned parallel with the ceiling as required by NFPA 13(99), Sec. 5-6.4.2.
- Network cable was found attached to the sprinkler piping in the basement Break Room, which does not meet the requirements of NFPA 25(98), Sec. 2-2.2.
- It was found that the restroom located off of the basement Break Room is not protected by fire sprinklers, which does not meet the requirements of NFPA 13(99), Sec. 1-6.1.

For purposes of this FSES, the various building levels were divided into five (5) separate smoke zones as follows:

Zone 1 – Basement
Zone 2 – Main Level Administrative Wing
Zone 3 – Main Level 100/200/300 Wings
Zone 4 – Main Level 400 Wing
Zone 5 – Main Level 500 Wing

This report is intended to serve as an explanation of the scores entered on Tables 1, 4 and 8 of the FSES worksheets (i.e. Forms CMS-2786T) for the facility as it was found on 11/07/11. The score assigned to each item is noted in brackets ([ ]). It must be noted that numbers were rounded to the nearest tenth of a point and that measurements of over one-half inch were rounded to the nearest inch. To ensure that the FSES addresses the "worst-case scenario", the product of the multiplication in Table 3B (i.e. value of "R") was rounded up to the nearest whole number. Code references are provided where appropriate. Codes referenced include the 2001 edition of NFPA 101A and the 2000 edition of the *Life Safety Code*® (NFPA 101).

With the exception of Table 8, which applies to all zones, this narrative will address each of the five (5) zones separately.

All Zones – TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET

In accordance with NFPA 101A(01), Sec. 4.7, Step 8, only one copy of this table is required to be filled out for each building. For convenience, however, this table was filled out on the worksheets for all zones evaluated. All items in Table 8 could be checked 'Met' with the exception of Items A, B and L. Because Renvilla Health Center is an existing facility and does not meet the definition of a high rise, Items B and L were checked 'Not Applicable'. Item A was identified as "Not Met" because a newly installed air conditioning unit in the food storage room located off of the kitchen on main level was found to be supplied by extension cord wiring instead of fixed wiring installed in conformance with the Electrical Code.

Note: The electrical issue identified above must be properly addressed in order for Renvilla Health Center to meet the requirements of NFPA 101(00), Sections 19.5.1 and 9.1.1 and pass the FSES.

The remaining items in Table 8 were identified as 'Met' based on the following:

- Other building utilities and heating and air conditioning systems appeared to be in conformance with applicable requirements.
- No incinerator or space heaters were found.
- The facility's evacuation plan was reviewed and appeared to be in order.
- A review of the Statement of Deficiencies from the 02/18/11 fire/life safety recertification survey revealed that Renvilla Health Center was cited for failure to conduct fire drills quarterly on each shift (see data tag K050). The facility subsequently submitted an acceptable Plan of Correction stating that its fire drill policy would be reviewed and drills conducted quarterly on each shift. Based on review of the facility's fire drill records, it was confirmed that drills are now being conducted in accordance with NFPA 101(00), Sec. 19.7.1.2.
- The facility's smoking regulations were reviewed and appeared to be in order. Renvilla Health Center is a smoke-free facility.
- With the exception of sheer curtains found hanging in the dayroom located between the 400 and 500 Wings on the main level, documentation review showed all draperies, cubicle curtains, upholstered furniture, mattresses and decorations to be in accordance with NFPA 101(00), Sec. 19.7.5. The "sheers" were removed. Documentation was provided certifying that the plantscapes (e.g faux trees) installed in the facility's public spaces are flame resistant when tested in accordance with NFPA 701.
- Portable fire extinguishers, EXIT signage and emergency lighting appeared to be provided in accordance with applicable requirements.

Zone 1 – Basement Level:

The facility's residents are not allowed in the basement. For purposes of this FSES, therefore, it was assumed that this level did not involve resident housing, treatment or customary access. The basement was found to house a staff break room and restroom, a mechanical room, three storage rooms, an elevator equipment room, and a staff in-service room. As a result, in accordance with instruction given in NFPA 101A(01), Sec. 4.3.2(4)a, only Item 3, Zone Location (*L*), of Table 1 was addressed and the value of factor *F* in Table 2, OCCUPANCY RISK FACTOR CALCULATION, was assigned a factor of 1.6 (i.e. the value assigned to basements in factor *L* of Table 1).

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: +2]:
   The building was assigned a Type II(111) construction type.

2. Interior Finish (Corridors and Exits) [Score: +3]:
   Walls in corridors and exits were found to be of masonry and plaster. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Walls in rooms were found to be of masonry and plaster. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: -10]:
   This score was assigned because of multiple unprotected conduit penetrations found in the wall separating the Storage Room from the corridor.
   See Table of Alternates: *If the penetrations were sealed with a listed through-penetration fire-stop system providing a fire resistance equal to that of the existing wall, the score for this Parameter would change to +2.*
5. Doors to Corridor [Score: 0]:
   This score was assigned per instruction in Footnote *d* to this Table. The corridor doors in this zone were found to be a mixture of 60-minute and 90-minute fire-rated doors in steel frames, but Parameter 4 was scored at -10.
   See Table of Alternates: *If Parameter 4 were scored at greater than -10, the score for this Parameter would change to +1.*
6. Zone Dimensions [Score: +1]:
   This zone measures approximately 90 feet in length and has no dead ends.
7. Vertical Openings [Score: -10]:
   This score was assigned because of an unprotected wiring penetration through the ceiling of the Mechanical Room.
   See Table of Alternates: *If the penetration were sealed with a listed through-penetration fire-stop system providing a fire resistance equal to that of the existing floor/ceiling assembly, the score for this Parameter would change to +2.*
8. Hazardous Areas [Score: -6]:
   This score was assigned for the following reasons:
   - Four (4) unprotected conduits and wiring and plumbing penetrations were found in the wall between the phone room/storage room and the In-service Room, and
   - Three (3) unprotected conduit penetrations were found in the wall between Therapy Storage and the In-service Room.

   See Table of Alternates: *If the penetrations were sealed with a listed through-penetration fire-stop system providing a fire resistance equal to that of the existing walls, the score for this Parameter would change to 0.*
9. Smoke Control [Score: 0]:
   This score was assigned per Footnote *c* to this Table and the fact that residents are not allowed on this level.
10. Emergency Movement Routes [Score: 0]:
    There are two remote exits from this zone .
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by Protection Systems, Inc.
12. Smoke Detection and Alarm [Score: 0]:
    This score was assigned because no smoke detectors were found and the zone is protected with standard-response sprinklers.

13. Automatic Sprinklers [Score: 0]:
    With the exception of the basement restroom, the building is protected throughout by a supervised automatic fire sprinkler system. Pursuant to the language in NFPA 101A(01), Sec. 4.4, however, no credit could be given for the sprinkler system, as it was not installed and maintained in accordance with NFPA 101(00), Sections 19.3.5.2 and 9.7.
    See Table of Alternates: *Once the sprinkler deficiencies noted previously in this report are addressed, the score for this Parameter will change to +10.*

Zone 2 – Main Level Administrative Wing:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 2.0]: There are no sleeping rooms in this zone. The zone contains the facility's South Dining Room, chapel, activity and therapy spaces, beauty shop and administrative offices, which are available for use by all residents. The zone also includes the dayroom space between the 400 and 500 Wings.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.2]: It was reported that there is one (1) staff person for each nine (9) residents present in this zone.
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents using this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: +2]:
   The building was assigned a Type II(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Walls in corridors and exits were found to be of masonry, gypsum wallboard and plaster. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   Walls in rooms were found to be of masonry, gypsum wallboard and plaster. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: 0]:
   Three 23" x 42" glass vision panels in metal frames were found in the corridor wall at the South Dining Room. As a result, the corridor walls were graded as "<½ hour".
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be a mixture of 1¾-inch-thick solid wood construction and 20-minute-rated door assemblies.
6. Zone Dimensions [Score: -2]:
   This zone measures approximately 176 feet in length and has no dead ends.
7. Vertical Openings [Score: -10]:
   This score was assigned because of the vertical opening deficiency found in the zone below (i.e. Zone 1 - Basement).
   See Table of Alternates: *When the vertical opening deficiency in the basement is corrected, the score for this Parameter will change to 0.*

8. Hazardous Areas [Score: -2]:
   This parameter was scored as a "Single Deficiency" because of the hazardous area deficiencies in the zone below (i.e. Zone 1 - Basement).
   See Table of Alternates: *When the hazardous area deficiencies in the basement are corrected, the score for this Parameter will change to 0.*
9. Smoke Control [Score: 0]:
   A smoke barrier serves this zone.
10. Emergency Movement Routes [Score: 0]:
    There are two remote exits from this zone.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by Protection Systems, Inc.
12. Smoke Detection and Alarm [Score: +2]:
    System-connected smoke detectors were found in the egress corridor and spaces open to the corridor.
13. Automatic Sprinklers [Score: 0]:
    With the exception of the basement restroom, the building is protected throughout by a supervised automatic fire sprinkler system. Pursuant to the language in NFPA 101A(01), Sec. 4.4, however, no credit could be given for the sprinkler system, as it was not installed and maintained in accordance with NFPA 101(00), Sections 19.3.5.2 and 9.7.
    See Table of Alternates: *Once the sprinkler deficiencies noted previously in this report are addressed, the score for this Parameter will change to +10.*

Zone 3 – Main Level 100/200/300 Wings:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.5]: There is bed capacity for up to 17 residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 1.5]: It was reported that there are two (2) staff persons on duty in this zone on the night shift. Because one staff person may be making rounds in other parts of the facility, this Parameter was scored as ">10 over One".
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents housed in this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: +2]:
   The building was assigned a Type II(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Walls in corridors and exits were found to be of masonry and plaster. Documentation was provided certifying that wall and ceiling finishes [i.e. aesthetics ("home front facades") installed in the corridors of the 100 and 200 wings and acoustical ceiling tile] carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   While most walls and ceilings in rooms were found to be plaster, acoustical ceiling tile was found in some rooms. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.

4. Corridor Partitions/Walls [Score: 0]:
   It was found that the spaces open to the corridor cited against the 100 and 200 Wings during the 02/18/11 fire/life safety recertification survey (see data tag K017) have been protected with automatic smoke detection to meet the exceptions to NFPA 101(00), Sec. 19.3.6.1. Three 23" x 52" glass vision panels in metal frames were found in the corridor wall at the main lobby. As a result, the corridor walls were graded as "<½ hour".
5. Doors to Corridor [Score: -10]:
   Corridor doors in this zone were found to be of 1¾-inch-thick solid wood construction with the exception of the door into Human Resources, which is of plain glass construction. This score was assigned because it was found that the glass corridor door is not positive latching as required by NFPA 101(00), Sec. 19.3.6.3.2, nor is the room protected by automatic smoke detection to meet the exceptions to NFPA 101(00), Sec. 19.3.6.1.
   See Table of Alternates:
   - *If the door to Human Resources were equipped with positive latching hardware, the score for this Parameter would change to 0 (see Alternate #1).*
   - *If the room were protected by automatic smoke detection to meet the exceptions to NFPA 101(00), Sec. 19.3.6.1, the score for this Parameter would change to +1 (see Alternate #2).*
6. Zone Dimensions [Score: -2]:
   This score was assigned per Footnote *c* to this Table (fewer than 31 residents). This zone measures approximately 200 feet in length and has no dead ends.
7. Vertical Openings [Score: 0]:
   This score was assigned because of the vertical opening deficiency found in the adjacent (Zone 2 - Main Level Administrative Wing). These zones are separated with construction providing less than 1-hour fire resistance.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone. It was found that the corridor door into the 300 Wing Soiled Utility Room cited during the 02/18/11 fire/life safety recertification survey (see data tag K029) has been equipped with positive latching hardware.
9. Smoke Control [Score: 0]:
   A smoke barrier serves this zone.
10. Emergency Movement Routes [Score: -2]:
    A review of the Statement of Deficiencies from the 02/18/11 fire/life safety recertification survey revealed that Renvilla Health Center was cited for the presence of interior finish materials mounted on the corridor walls in the 100 and 200 Wings that diminished the width of the existing corridors by up to 5¼ inches (see data tag K072). In addition, grab rails mounted on the corridor walls of the 100 and 200 Wings were cited for projecting 5 inches to 5½ inches into the corridors as measured from the original corridor wall to the outside edges of the wooden rails. While the resulting clear width of the corridors still exceeds the 4 ft clear width required by NFPA 101(00), Sec. 19.2.3.3, the reduction of the original 82¼-inch corridor width does not meet the requirements of NFPA 101(00), Sec. 4.6.7.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by Protection Systems, Inc.
12. Smoke Detection and Alarm [Score: +2]:
    System-connected smoke detectors were found in the egress corridor and spaces open to the corridor.

13. Automatic Sprinklers [Score: 0]:
    With the exception of the basement restroom, the building is protected throughout by a supervised automatic fire sprinkler system. Pursuant to the language in NFPA 101A(01), Sec. 4.4, however, no credit could be given for the sprinkler system, as it was not installed and maintained in accordance with NFPA 101(00), Sections 19.3.5.2 and 9.7.
    See Table of Alternates: *Once the sprinkler deficiencies noted previously in this report are addressed, the score for this Parameter will change to +10.*

Zone 4 – Main Level 400 Wing:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 1.6]: It was reported that all residents housed in this zone are capable of removing themselves from danger exclusively by their own efforts. To ensure that the FSES addresses the "worst-case scenario", this Parameter was scored as "Limited Mobility" to account for the fact that the rate of travel for some of the residents may be slowed due to mobility impairments.
2. Patient Density (*D*) [Value assigned = 1.0]: There is bed capacity for up to five (5) assisted living residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 4.0]: It was reported that the south nurse station is not staffed on a 24-hour basis, but that staff from the north nurse station and staff from the adjacent 1993 addition (i.e. Building 02 – Centennial Circle) makes rounds in this zone every 2 hours. Because the zone is not constantly attended, this Parameter was scored as "One or More over None".
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents housed in this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

1. Construction [Score: +2]:
   The building was assigned a Type II(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that wall and ceiling finishes (i.e. vinyl wall coverings and acoustical ceiling tile) in corridors and exits carry a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   While most walls and ceilings in rooms were found to be plaster, acoustical ceiling tile was found in some rooms. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls were determined to be constructed of glazed block and plaster.
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1¾-inch-thick solid wood construction.
6. Zone Dimensions [Score: +1]:
   This zone measures approximately 86 feet in length and has no dead ends.
7. Vertical Openings [Score: 0]:
   This score was assigned because of the vertical opening deficiency found in the adjacent zone (i.e. Zone 2 - Main Level Administrative Wing). These zones are separated with construction providing less than 1-hour fire resistance.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.

9. Smoke Control [Score: 0]:
   A smoke barrier serves this zone.
10. Emergency Movement Routes [Score: 0]:
    There are two remote exits from this zone.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by Protection Systems, Inc.
12. Smoke Detection and Alarm [Score: +2]:
    System-connected smoke detectors were found in the egress corridor and spaces open to the corridor.
13. Automatic Sprinklers [Score: 0]:
    With the exception of the basement restroom, the building is protected throughout by a supervised automatic fire sprinkler system. Pursuant to the language in NFPA 101A(01), Sec. 4.4, however, no credit could be given for the sprinkler system, as it was not installed and maintained in accordance with NFPA 101(00), Sections 19.3.5.2 and 9.7.

Zone 5 – Main Level 500 Wing:

TABLE 1. OCCUPANY RISK PARAMETER FACTORS

1. Resident Mobility (*M*) [Value assigned = 3.2]: It was reported that some residents in the zone may need assistance with evacuation.
2. Patient Density (*D*) [Value assigned = 1.2]: There is bed capacity for up to seven (7) residents in this zone.
3. Zone Location (*L*) [Value assigned = 1.1]: This zone is less than one-half floor height above grade.
4. Ratio of Patients to Attendants (*T*) [Value assigned = 4.0]: It was reported that the south nurse station is not staffed on a 24-hour basis, but that staff from the north nurse station and staff from the adjacent 1993 addition (i.e. Building 02 – Centennial Circle) makes rounds in this zone every 2 hours. Because the zone is not constantly attended, this Parameter was scored as "One or More over None".
5. Patient Average Age (*A*) [Value assigned = 1.2]: Residents housed in this zone average over 65 years of age.

TABLE 4. SAFETY PARAMETERS and SAFETY PARAMETER VALUES

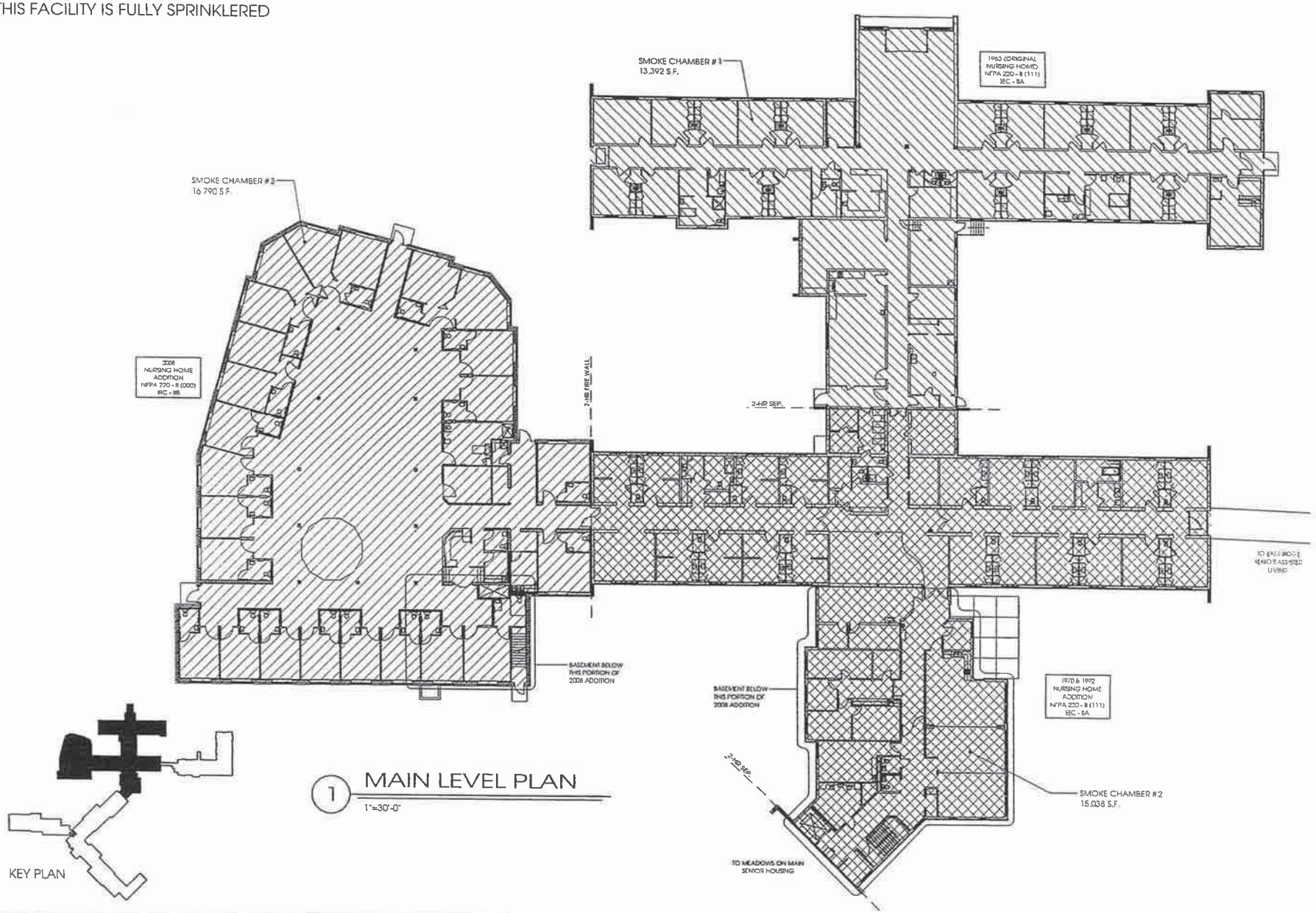
1. Construction [Score: +2]:
   The building was assigned a Type II(111) construction type.
2. Interior Finish (Corridors and Exits) [Score: +3]:
   Documentation was provided certifying that:
   - The ceiling finishes (i.e. acoustical ceiling tile) carry a Class A (25 or less) flame spread rating, and
   - The wood wainscot on the corridor walls was treated with Flame Control Fire Retardant Clear Satin Varnish to achieve a Class A (25 or less) flame spread rating.
3. Interior Finish (Rooms) [Score: +3]:
   While most walls and ceilings in rooms were found to be plaster, acoustical ceiling tile was found in some rooms. Documentation was provided certifying that the acoustical ceiling tile carries a Class A (25 or less) flame spread rating.
4. Corridor Partitions/Walls [Score: +2]:
   Corridor walls were found to be constructed of glazed block and plaster. It was found that the space open to the corridor cited during the 02/18/11 fire/life safety recertification survey (see data tag K017) has been protected with automatic smoke detection to meet the exceptions to NFPA 101(00), Sec. 19.3.6.1.
5. Doors to Corridor [Score: +1]:
   Corridor doors in this zone were found to be of 1¾-inch-thick solid wood construction.

6. Zone Dimensions [Score: +1]:
   This zone measures approximately 74 feet in length and has no dead ends.
7. Vertical Openings [Score: 0]:
   This score was assigned because of the vertical opening deficiency found in the adjacent zone (i.e. Zone 2 - Main Level Administrative Wing). These zones are separated with construction providing less than 1-hour fire resistance.
8. Hazardous Areas [Score: 0]:
   No hazardous area deficiencies were found in this zone.
9. Smoke Control [Score: 0]:
   A smoke barrier serves this zone.
10. Emergency Movement Routes [Score: +1]:
    This zone is served by a horizontal exit that discharges into Building 02 – Centennial Circle.
11. Manual Fire Alarm [Score: +2]:
    Manual fire alarm pull stations are provided in accordance with NFPA 101(00), Sec. 19.3.4.2. The fire alarm system is monitored by Protection Systems, Inc.
12. Smoke Detection and Alarm [Score: +2]:
    System-connected smoke detectors were found in the egress corridor and spaces open to the corridor.
13. Automatic Sprinklers [Score: 0]:
    With the exception of the basement restroom, the building is protected throughout by a supervised automatic fire sprinkler system. Pursuant to the language in NFPA 101A(01), Sec. 4.4, however, no credit could be given for the sprinkler system, as it was not installed and maintained in accordance with NFPA 101(00), Sections 19.3.5.2 and 9.7.

* * * * * * * * * * * *

It must be noted that the scores and values assigned to the parameters in the tables on the FSES worksheets are based on conditions found between 0905 hours and 1715 hours on 11/07/11. Any changes in those conditions after this date could affect those scores and values, either positively or negatively. Again, based on this evaluation, Renvilla Health Center **has not** achieved a passing score on the FSES. No other assessment of the level of safety in this facility is either intended or implied by *Fire Safety Resources, LLC.*

THIS FACILITY IS FULLY SPRINKLERED



1 MAIN LEVEL PLAN

1"=30'-0"

KEY PLAN

DATE	11-29-11
PROJECT NO	110307
COMPUTER NO	110307 CODES
DRAWN BY	K.A.C

REVISIONS
DATE

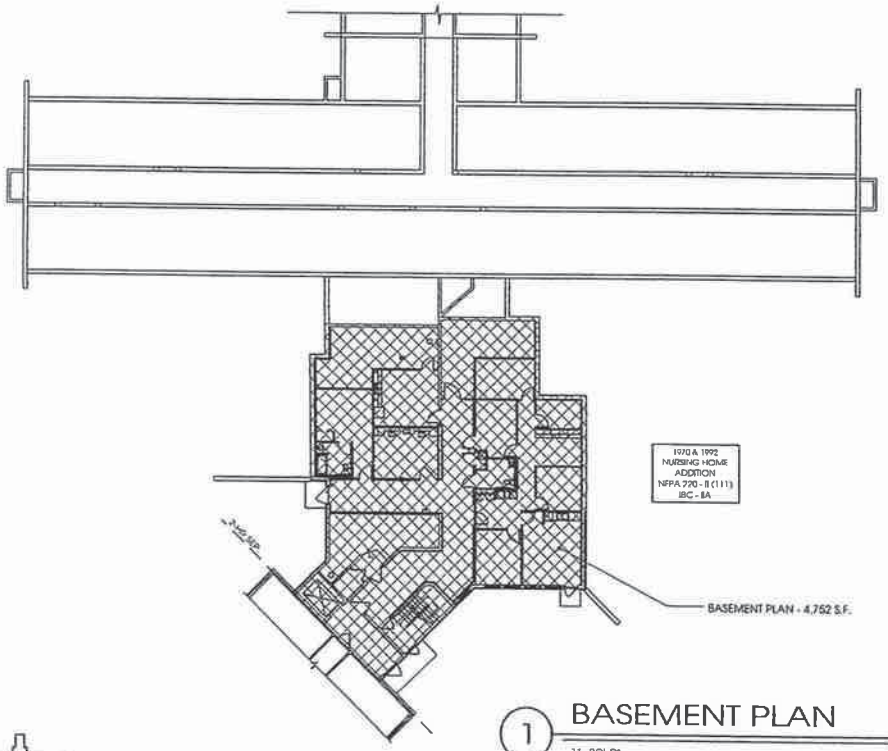
PRAIRIE DESIGN STUDIO

RENVILLA HEALTH CENTER
RENVILLE, MN

ST. FRANCIS HEALTH SERVICES
MORRIS, MN

A-1

THIS FACILITY IS FULLY SPRINKLERED



1 BASEMENT PLAN
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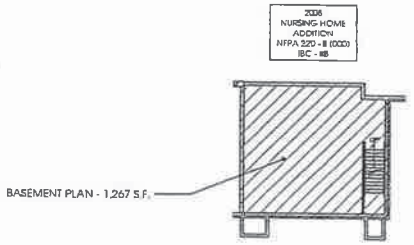

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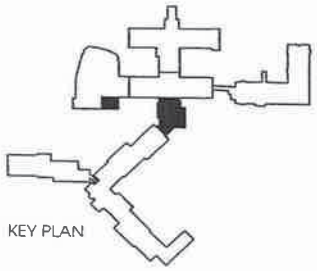


DATE	11-29-11
PROJECT NO	110307
COMPUTER NO	110307 CODES
DRAWN BY	KAC

REVISIONS

DATE

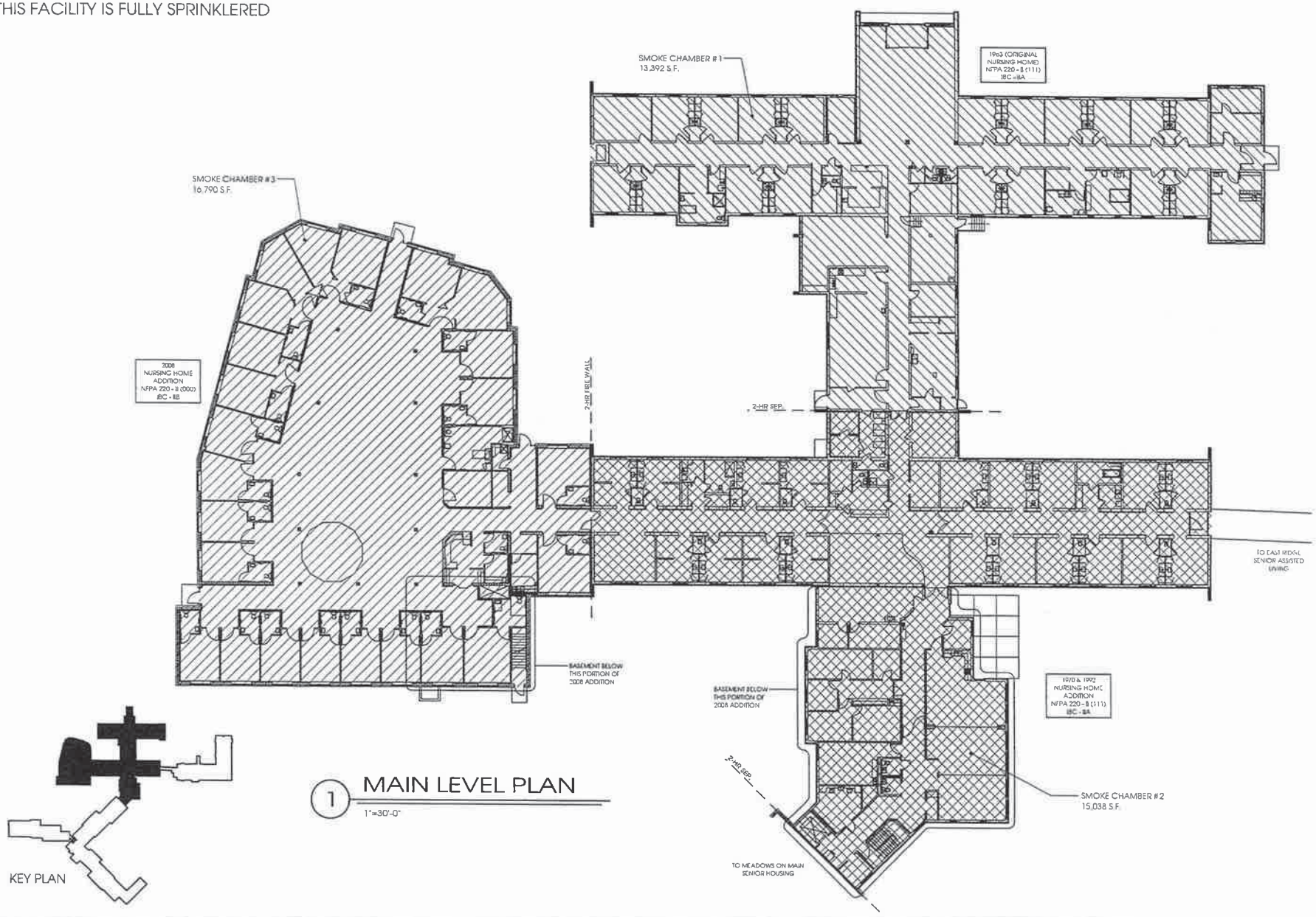
PRAIRIE DESIGN STUDIO

RENVILLA HEALTH CENTER
RENVILLE, MN

ST. FRANCIS HEALTH SERVICES
MORRIS, MN

A-2

THIS FACILITY IS FULLY SPRINKLERED



1 MAIN LEVEL PLAN

1"=30'-0"

DATE	11 - 29 - 11
PROJECT NO	110307
COMPUTER NO	110307 CODES
DRAWN BY	KAC

REVISIONS

DATE	

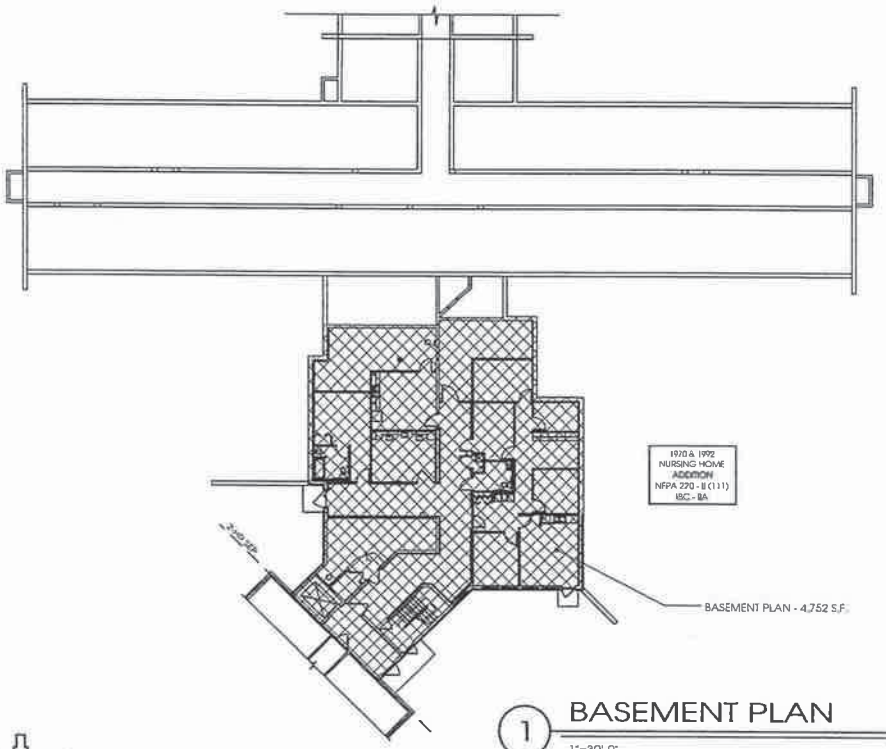
PRAIRIE DESIGN STUDIO

RENVILLA HEALTH CENTER
RENVILLE, MN

ST. FRANCIS HEALTH SERVICES
MORRIS, MN

A-1

THIS FACILITY IS FULLY SPRINKLERED



1 BASEMENT PLAN
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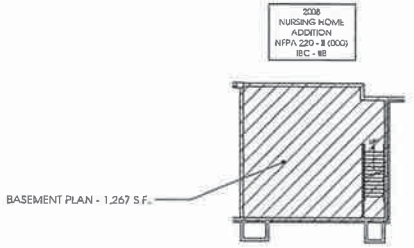

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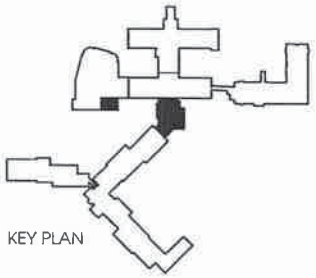

KEY PLAN

DATE	11-29-11
PROJECT NO	110307
COMPUTER NO	110307 CODES
DRAWN BY	KAC

REVISIONS
DATE

PRAIRIE DESIGN STUDIO

ST. FRANCIS HEALTH SERVICES
MORRIS, MN

RENVILLA HEALTH CENTER
RENVILLE, MN

A-2

RenVilla Health Center

FSES Plan of Correction according to table of Alternates

12/2/2011

Submitted by James Ingersoll, LNHA

FSES Deficiency: The escutcheon plate was found to be missing from a pendent spray sprinkler head in the food storage room located off of the kitchen. This does not meet the requirements of NFPA 13(99), Sections 3-2.7 and 5-3.1.1

Providers Plan of Correction: Escutcheon plate replaced

Person Responsible: Environmental Services Director

Date of Completion: 11/8/2011

FSES Deficiency: Paint was found on a sprinkler head located near the restroom in the basement Break Room, which does not meet the requirements of NFPA 13(99), Sec. 3-2.6.3 and NFPA 25(98), Sec. 2-2.1.1

Providers Plan of Correction: Sprinkler head replaced

Person Responsible: Environmental Services Director

Date of Completion: 11/8/2011

FSES Deficiency: It was observed that the deflector on one of the upright sprinkler heads in the basement Storage Room was damaged so that it was not aligned parallel with the ceiling as required by NFPA 13(99), Sec. 5-6.4.2

Providers Plan of Correction: Sprinkler head replaced

Person Responsible: Environmental Services Director

Date of Completion: 11/8/2011

FSES Deficiency: Network cable was found attached to the sprinkler piping in the basement Break Room, which does not meet requirements of NFPA 25(98), Sec. 2-2.2

Providers Plan of Correction: Network cable removed from sprinkler pipe and installed in proper fashion

Person Responsible: Environmental Services Director

Date of Completion: 11/29/2011

FSES Deficiency: It was found that the restroom located off of the basement Break Room is not protected by fire sprinklers. This does not meet the requirements of NFPA 13(99), Sec. 1-6.1

Providers Plan of Correction: Sprinkler installed

Person Responsible: Environmental Services Director

Date of Completion: 11/8/2011

FSES Deficiency: Multiple unprotected conduit penetrations were found in the wall separating the Storage Room from the basement corridor.

Providers Plan of Correction: Penetrations sealed with a listed through-penetration fire-stop system

Person Responsible: Environmental Services Director

Date of Completion: 11/30/2011

FSES Deficiency: An unprotected wiring penetration was observed through the ceiling of the Mechanical Room on the basement level.

Providers Plan of Correction: Penetrations sealed with a listed through-penetration fire-stop system

Person Responsible: Environmental Services Director

Date of Completion: 11/30/2011

FSES Deficiency: Four (4) unprotected conduits and wiring and plumbing penetrations were found in the wall between the phone room/storage room and the In-service Room on the basement level.

Providers Plan of Correction: Penetrations sealed with a listed through-penetration fire-stop system

Person Responsible: Environmental Services Director

Date of Completion: 11/30/2011

FSES Deficiency: Three (3) unprotected conduit penetrations were found in the wall between Therapy storage and the In-service Room on the basement level.

Providers Plan of Correction: Penetrations sealed with a listed through-penetration fire-stop system

Person Responsible: Environmental Services Director

Date of Completion: 11/30/2011

FSES Deficiency: It was observed that the plain glass door to Human Resources in the 100 Wing on main level is not positive latching, nor is the room protected by automatic smoke detection to meet the exceptions to NFPA 101 (00), Sec. 19.3.6.1

Providers Plan of Correction: Room is now protected by automatic fire detection

Person Responsible: Environmental Services Director

Date of Completion: 11/24/2011

_____

James B. Ingersoll, CEO/Administrator

Renville Health Services

_____

Date

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8043 8928

March 21, 2012

Mr. James Ingersoll, Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, Minnesota 56284

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5554023

Dear Mr. Ingersoll:

The above facility was surveyed on March 13, 2012 through March 13, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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.

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, 3333 West Division Street, Suite 212, St. Cloud, Minnesota 56301-4557. 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,

Marge Meeker

Marge Meeker, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (320) 223-7317 Fax: (320) 223-7348

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00557	A. BUILDING _____ B. WING _____	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	**205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284**

(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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On, March 5,6,7 and 8, 2012, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00557	A. BUILDING _____ B. WING _____	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

(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) COMPLETE DATE
2 000	Continued From page 1 Certification Program; 3333 West Division St, Suite 212, St. Cloud, MN 56301-4557	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.	
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00557	A. BUILDING _____ B. WING _____	03/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

(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) COMPLETE DATE
2 570	Continued From page 2 quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to review and revise the care plan to include all current interventions and treatments to maintain/improve range of motion and prevent contractures 1 of 2 residents (R3) reviewed in the sample. Findings include: Resident 3 (R3) did not have current interventions for leg positioning splint use identified in the care plan. A functional maintenance plan for their use was not developed or added to the care plan. R3 had diagnoses that included previous cerebrovascular accident with left side hemiparesis, diabetes mellitus, obesity, anxiety, depression, current pressure ulcer on buttocks, and left tibial fracture 8/2010. The most recent quarterly minimum data set (MDS) dated 1/4/12 identified R3 as cognitively independent (brief interview mental status BIMS=13), with several indicators of mood disorder and totally dependent on two or more staff for bed mobility and transfers. Neither this MDS, nor the admission MDS dated 7/20/11, the quarterly MDS dated 10/12/11 and a discharge MDS dated 2/4/12 at the time of a hospitalization, correctly identified R3 with an impairment in functional range of motion on the left side extremities. Physical therapy plan of care dated 12/28/11 and	2 570		

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2 570	Continued From page 3 progress notes dated 2/8/12 identified R3 with left hand contracture, the left knee lacked 20 degrees of extension and R3 used lower extremity positioning boots to affect joint misalignment and discomfort and prevent external rotation contracture formation. R3's current care plan dated 1/12/12 noted the focus area of restorative nursing was to maintain range of motion and included interventions for range of motion exercise to extremities six (6) days/week and after range of motion was completed to the left hand, application of a blue hand splint that was to be removed after supper or as tolerated. Neither the care plan nor the nursing assistant "To Do List Report" care sheet identified the use or schedule for use of the lower extremity positioning boots. Additionally, use of a left leg ankle foot orthosis (AFO) was not identified in the care plan. The unit registered nurse(RN)-A verified at 9:15 a.m. on 3/7/12, R3 should have a functional maintenance plan in the record and on the care plan that identified use of the positioning boots; however, could not locate one. RN-A also verified the photo on the closet did not include a wear schedule or other approaches or alternatives to use for refusals of the splint. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are reviewing and revising the care plan as indicated and then providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 570		

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2 895	Continued From page 4	2 895		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide/document completion of all treatments and services to maintain/improve range of motion and prevent contractures for 1 of 2 residents (R3) in the sample. Findings include: R3 did not have current interventions for leg positioning splint use, identified in the care plan and a functional maintenance plan for their use was not developed. Not all staff were trained in use of the splints and/or were not aware of a schedule for wear. Additionally, R3 frequently refused to wear the splints; however, other alternatives or approaches to maintain proper positioning of the legs were not evaluated or attempted.	2 895		

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2 895	Continued From page 5 R3 had diagnoses that included previous cerebrovascular accident with left side hemiparesis, diabetes mellitus, obesity, anxiety, depression, current pressure ulcer on buttocks, and left tibial fracture 8/2010. The most recent quarterly minimum data set (MDS) dated 1/4/12, identified R3 as cognitively independent (brief interview mental status BIMS=13), with several indicators of mood disorder and was totally dependent on two or more staff for bed mobility and transfers. Neither this MDS, nor the admission MDS (dated 7/20/11), the quarterly MDS (dated 10/12/11) and a discharge MDS (dated 2/4/12) at the time of a hospitalization, correctly identified R3 with an impairment in functional range of motion on the left side extremities. Physical therapy (PT) plan of care, dated 12/28/11, and progress notes, dated 2/8/12, identified R3 with left hand contracture, the left knee lacked 20 degrees of extension and R3 used lower extremity positioning boots to affect joint misalignment and discomfort and prevent external rotation contracture formation. The PT goals for the plan of care included, [PT] to develop and train caregivers on an appropriate lower extremity nursing program by 2/29/12 and "The patient will tolerate lower extremity positioning boots to achieve effective positioning in bed by 3/8/12." A PT note,dated 2/10/12, identified the comment made by R3, "I don't like the braces (AFOs), too hot on my feet." R3's current care plan, dated 1/12/12, noted the focus area of restorative nursing to maintain	2 895		

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2 895	Continued From page 6 range of motion and included interventions for range of motion exercise to extremities 6 days/week and after range of motion was completed to the left hand, application of a blue hand splint that was to be removed after supper or as tolerated. Neither the care plan nor the nursing assistant "To Do List Report" care sheet identified the use or schedule for use of the lower extremity positioning boots. Observations of R3 during the survey noted the positioning boots always located on the window shelf, not applied to R3. A photo of the boot application process was located on the closet door. There was no schedule for wear posted in the room. The physical therapist reported during interview at 3:00 p.m. on 3/6/12, he was not sure what the wear schedule of the leg positioning splints were and thought there was a functional maintenance plan on their use. The PT also stated, "He (R3) hates them, we started having nursing put them on him but the program won't be complete until we discharge him from PT." R3 reported during interview at 7:45 a.m. on 3/7/12, he did not wear the leg splints at all the previous night, "I don't like them and don't wear them any more; at least I'm honest." Nursing assistant(NA)-C, who had worked the night of 3/7/12, stated at 9:12 a.m. the leg splint use should be on the aides "To Do List"; however, was not. NA-C added, " I have never been shown how to put them on, sometimes he wears them, sometimes he doesn't. If he refuses, we tell the nurse and she charts it." The unit registered nurse (RN)-A verified at 9:15	2 895		

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2 895	Continued From page 7 a.m. on 3/7/12, R3 should have a functional maintenance plan in the record and on the care plan that identified use of the positioning boots; however, could not locate one. RN-A also verified the photo on the closet did not include a wear schedule or other approaches or alternatives to use for refusals of the splint and it was nursing staff, not physical therapy or restorative nursing, that was expected to apply the positioning splints on a daily basis. At 11:05 a.m. on 3/7/12, RN-A reported she had not yet located a functional maintenance plan for the leg splint use and stated, "I'm still working on it." SUGGESTED METHOD FOR CORRECTION: The DON, director of therapy or designee(s) could review and revise as necessary the policies and procedures regarding implementing and maintaining proper range of motion services. The DON, director of therapy or designee(s) could provide an in-service for all appropriate staff on providing treatment per each resident ' s plan of care. The DON, director of therapy or designee(s) could monitor to assure residents receive proper range of motion treatment. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	2 895		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.	21015		

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21015	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure store, prepare, distribute and serve food under sanitary conditions. This had the potential to affect 46 of 46 residents in the facility. Findings include: The facility did not date food items stored in the refrigerator, record temperatures of refrigerators on both the north and south dining rooms, ensure the cleanliness of the north kitchenette and serve/distribute food to residents in a sanitary manner. During initial tour at 1:45 p.m. on 3/5/12, undated food items were observed in the refrigerator, located in the South dining room. Sliced cheese was noted to be in an unlabeled, undated Ziploc bag in the refrigerator door. Two open, half-full maple syrup bottles were also located in the refrigerator door and were noted to be undated. A temperature log, dated 3/12 was taped to the outside of the refrigerator door. The temperature log lacked records of refrigerator temperatures for 3/1/12 through 3/5/12. The temperature at the time of observation was noted as 40 degrees Fahrenheit (F). During interview at 5:40 p.m. on 3/5/12, the director of dietary (DD) reported that a family member must have brought the sliced cheese into the facility and put it in the facility's refrigerator. DD added, "We don't even have that kind of cheese here." DD verified that the syrup bottles should have been dated with the date they were opened. DD verified the refrigerator	21015		

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21015	Continued From page 9	21015		

temperatures were not being checked and recorded daily, as per the facility's policy. DD reported that the dietary aides were responsible for checking the refrigerators on a daily basis to ensure food items were stored or disposed of as appropriate. DD added, dietary aides were also responsible for checking and recording the refrigerator temperatures on a daily basis.

Review of the facility's Food Labeling Policy and Procedure, dated 7/1/11, revealed that all foods needed to have a label and date on the container that was to be stored in the cooler or freezer. All packages/boxes needed to be labeled, identifying what was inside and the date opened. The policy added that any open container without an opened date on it would be thrown away immediately.

Review of the facility's undated policy for Record of Refrigeration Temperatures, revealed that the dietary manager was to assign an employee to record all refrigerator and freezer temperatures on a daily basis.

At 4:22 p.m. on 3/5/12, the north kitchenette was toured. The refrigerator in the kitchenette had spilled juice/milk and a sticky substance on the shelves. A large dried brown substance was also observed on the floor of the base of the sink cabinet. The floor in the corner of the kitchenette under a wheeled dietary cart had a large amount of dried food debris.

At 7:15 a.m. on 3/7/12, the debris beneath the wheeled food cart and the spilled juice/milk and the sticky substance on the shelves of the refrigerator was still present. An interview with dietary aide (DA)-C was completed. DA-C verified the spills in the refrigerator and the large food debris under the dietary cart. DA-C reported the

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21015	Continued From page 10 dietary staff are responsible to spot clean the refrigerator, whenever they put food items into it. DA-C thought that the housekeeping staff was responsible for cleaning everything else in the kitchenette. At 7:55 a.m. on 3/7/12, an interview with the dietary manager (DM) was completed. DM verified the interior of the refrigerator was not clean and had milk/juice spills and a sticky substance on the shelf. DM reported that the dietary staff is to ensure the cleanliness of the interior of the kitchen. DM reported she had talked to the dietary staff and discovered that the spot cleaning had not been done the past two days. DM also reported that no schedule was in place for deep cleaning of the refrigerator by the dietary staff. DM indicated the housekeeping staff is responsible for cleaning everything in the kitchenette, other than the interior of the refrigerator. DM verified that floor by wheeled food cart had significant debris build up and the base of the cabinet under the sink was dirty. At 11:44 a.m. 3/7/12, an interview with housekeeping staff (HS)-A was completed. HS-A reported she was responsible for the cleanliness of the kitchenette on the north wing. She reported she cleaned the floor daily, generally after the noon meal. HS-A verified the build up of debris on the floor. HS-A attempted to remove the wheeled cart from the kitchenette but was unable to do so. After HS-A was unable to remove the wheeled cart from the kitchenette, she attempted to clean under the cart with a broom. The broom did not reach all the debris under and surrounding the cart in the alcove. During the evening meal of 3/5/12 on the Centennial unit, several staff were noted to serve	21015		

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21015	Continued From page 11 food without disinfecting/washing hands between serving multiple residents and after touching the residents, furniture and ready to serve/eat food items. The evening supper meal observation beginning at 5:25 p.m. on 3/5/12 included ham salad on a bun, sandwich, soup, coleslaw and french fries. Observation of dietary staff-A (DA-A) who served the meal revealed use of gloves; however, during the course of serving the meal, DA-A was noted to touch shelving, her clothing items and other nearby surfaces and then used the gloved fingers to remove the ham salad on to the plate for residents who did not want a bun. No utensils were used to scrape the ham salad off the buns. In addition, nursing assistants (NA) -A, and C were observed to deliver food to each resident seated at the tables without washing or disinfecting hands between the contacts. During the delivery process, NA-A and NA-C were noted to touch residents, resident's clothing, their own clothing, furniture items and other surfaces as well as bare hand contact with the burger buns and sandwiches. Upon returning to the serving area, no hand washing or alcohol based disinfection was observed. NA-A was also observed to deliver food to resident's rooms without disinfection noted before serving others. A SUGGESTED METHOD FOR CORRECTION: The administrator and/or dietician could review and revise food service policies and procedures to assure that food is stored and served in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager could monitor the service of food on a periodic basis.	21015		

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21015	Continued From page 12 TIME PERIOD FOR CORRECTION: Thirty (30) days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease and infections (use and cleaning of community electric razors) in one of four bathing rooms. This practice had the potential to affect four residents in the facility. Finding include: At 3:15 p.m. on 3/5/12, three electric razors were observed on a table in the tub room on the north wing of the facility. One of the electric razors had a significant build up of hair in the head of the razor. An interview with nursing assistant (NA)-E was completed at 3:15 p.m. on 3/5/12. NA-E reported the community razor is used on most of the resident but a few residents have their own razors. NA-E reported the razors were to be cleaned after each resident use, but was unsure of the procedure to do so. NA-E verified the significant build up of hair and described the condition of the head of the razor as "gross." .	21375		

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21375	Continued From page 13 At 4:56 p.m. on 3/5/12, an interview with the director of nursing (DON) was completed. The DON reported that she believed most of the residents at the facility had their own razors. The DON indicated if a community razor is used, the razor is to be cleaned with alcohol between each resident use. The DON verified the presence of the three community razors in the north tub room and also indicated that the debris build up on one of the razors was not acceptable and needed to be cleaned. The facility policy and procedure labeled "Cleaning Razors", dated 11/09, was received. The policy indicated the facility was to "make sure resident razors and facility razors are cleaned and disinfected to prevent spread of infection." The procedure for cleaning facility razors directed staff, after each resident use to open the top of the razor and clean off excess hair from inside the razor with razor brush. Staff were then instructed to wipe off the outside of the razor with alcohol pad and allow to dry. This was not followed. Suggested Method of Correction: The infection preventionist or designee could review policies and procedures to ensure proper infection control techniques are followed. Facility staff could be reeducated and an auditing system developed to ensure compliance. Time Period for Correction: Twenty one (21) days.	21375		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive	21565		

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21565	Continued From page 14 resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to determine if the practice of self-administration of medications was safe for 1 of 1 resident (R3) in the sample observed self-administering medication. Findings include: R3 was observed to self-administer a nebulizer treatment. The resident lacked a self-administration of medications assessment. A trained medication assistant (TMA)-B was observed at 9:38 a.m. on 3/7/12 to take a vial of DuoNeb (a medication that is used to aid breathing) into R3's room, pour the medication into a nebulizer machine, place the face mask on R3 and start the nebulizer machine. TMA-B informed R3, she (the TMA) would be setting an alarm on her medication cart and when the alarm went off, she would return and remove the mask. An interview at 9:41 a.m. on 3/7/12 with TMA-B, revealed R3 had a history of removing the mask prior to the nebulizer treatment being completed. R3's entry minimum data set (MDS) dated 2/7/12 , indicated R3 required extensive assistance or total dependence with activities of daily living, other than eating and use of electric wheelchair. R3 was independent in those areas. R3 was moderately impaired of cognition. R3's physician orders dated 2/29/12 included	21565		

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RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

(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) COMPLETE DATE
21565	Continued From page 15 DuoNeb Inhalation Solution qid (four times per day). There was no physician order authorizing R3 to self-administer medications. An interview with the director of nursing (DON) at 9:57 a.m. on 3/7/12 was completed. The DON verified that R3 was self-administering the nebulizer and an assessment should be done prior to doing so. The DON verified that an assessment had not been done. The facility's policy, dated 2/10, indicated the facility is to assess any resident who wishes to self-administer medication to ensure the resident is safe to do so. The policy also directed staff document on the medication record (MAR) or the treatment record (TAR) if the resident is able to self-administer medication. There was no documentation on the MAR or TAR for R3 to self administer medications. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review and revise the policies and procedures for the resident self-administration assessment/protocol and care planning, educate the appropriate personnel in any changes and appoint a designee to monitor the procedures to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21565		