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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: INJC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00762

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245579**

2.STATE VENDOR OR MEDICAID NO.
(L2) **030525100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH GRACE HOME**
(L4) **116 WEST SECOND STREET**
(L5) **GRACEVILLE, MN** (L6) **56240**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/28/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(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 :
Gail Anderson, Unit Supervisor 04/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/01/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/08/1991
(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
05/01/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5579

On April 28, 2014 this Department completed a Post Certification Revisit (PCR) by review of the facility's plan of correction and on April 25, 2014 the Department of Public Safety completed a PCR. Based on the plan of correction, we have determined that the deficiencies issued pursuant to the standard survey completed on March 6, 2014 have been corrected, effective April 15, 2014. Refer to the CMS 2567b for both health and life safety code for the results of this visit.

Effective April 15, 2014, the facility is certified for 45 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5579

June 8, 2014

Mr. Kevin Gish, Administrator
Essentia Health Grace Home
116 West Second Street
Graceville, Minnesota 56240

Dear Mr. Gish:

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 15, 2014 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 6, 2014

Mr. Kevin Gish, Administrator
Essentia Health Grace Home
116 West Second Street
Graceville, Minnesota 56240

RE: Project Number S5579024

Dear Mr. Gish:

On March 24, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 6, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On April 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 25, 2014 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 6, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 15, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 6, 2014, effective April 15, 2014 and therefore remedies outlined in our letter to you dated March 24, 2014, 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.

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

Sincerely,

Mark Meath

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

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

cc: Licensing and Certification File 5579r14.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245579	A. Building B. Wing	4/28/2014

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA HEALTH GRACE HOME	116 WEST SECOND STREET GRACEVILLE, MN 56240

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 **03/26/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **04/15/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **04/15/2014**
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **04/15/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **04/09/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/09/2014**
ID Prefix **F0466** Reg. # **483.70(h)(1)** LSC	Correction Completed **04/12/2014**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/GA	05/06/2014	28034	04/28/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/6/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245579	A. Building / B. Wing: 01 - MAIN BUILDING 01	4/25/2014

Name of Facility	Street Address, City, State, Zip Code
ESSENTIA HEALTH GRACE HOME	116 WEST SECOND STREET GRACEVILLE, MN 56240

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0022	Correction Completed 03/10/2014	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 03/18/2014	ID Prefix Reg. # NFPA 101 LSC K0069	Correction Completed 04/14/2014
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By MM/PS	Date: 05/06/2014	Signature of Surveyor: 27200	Date: 04/25/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/5/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 7VV7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00762

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245579**
2.STATE VENDOR OR MEDICAID NO.
(L2) **030525100**

3. NAME AND ADDRESS OF FACILITY
(L3) **ESSENTIA HEALTH GRACE HOME**
(L4) **116 WEST SECOND STREET**
(L5) **GRACEVILLE, MN** (L6) **56240**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/24/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(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):
At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE — Date :
Denise Erickson, HFE NEII — 04/16/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 05/01/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/08/1991
(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 04/18/2013 CO.
7VV7

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4585

March 24, 2014

Ms. Kevin Gish, Administrator
Essentia Health Grace Home
116 West Second Street
Graceville, Minnesota 56240

RE: Project Number S5579024

Dear Ms. Gish:

On March 6, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858

Phone: (218) 332-5140
Fax: 218-332-5196

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 15, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 15, 2014 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 6, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 6, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5579s14.rtf

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
	245579	A. BUILDING _____ B. WING _____	03/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH GRACE HOME	116 WEST SECOND STREET GRACEVILLE, MN 56240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	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 failed to ensure state agency survey results were clearly accessible to visitors, family or residents who wished to review them without asking facility staff. This had the potential to affect all 43 residents in the facility. Findings include: During the initial tour on 3/3/14, at 1:15 p.m., an alcove in the facility, which measured	F 167	The most recent survey results have been placed in a new binder with identification on the front, back and binding of the binder stating (Grace Home Survey Results). The binder is now located in the alcove across the hall from the rest rooms near the main lobby. A sign has been posted on the main entrance identifying the location of the results. The facility will continue to inform residents and families of the placement of these results during care conferences. Business Office Staff will monitor that the results are in the correct location weekly X 4 weeks. per tracking log. These results will be reviewed by the Quality Assurance Committee for further monitoring recommendations.	3/20/14 3/26/14 4/16/14 OK JA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joan D. Link, LNHA | TITLE: Administrator | (X6) DATE: 4-14-14

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

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	245579	A. BUILDING _____ B. WING _____	03/06/2014

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F 167	Continued From page 1 approximately 12 inches (in.) deep and 3 feet wide, was located at the end of a hallway near the lobby of the facility. The alcove had two shelves which extended across the width of the alcove approximately three feet from the floor. Mounted approximately 3 inches from the floor, two shelves were observed with approximately 3 inches between the two shelves. The top shelf contained a maroon-colored fabric runner with two statuettes on opposite ends of the runner. In addition, several loose paper leaflets were between the statuettes. On the lower shelf, a teal-colored, three ring binder was observed with the spine of the binder facing the hallway. The front cover of the binder was labeled as containing the survey results, however, as the front cover was obscured by the upper shelf, the information was not clearly visible to persons walking in the hallway. In addition, the facility had not posted a notice to indicate the location of the survey results in the facility. During subsequent observations on 3/4, 3/5 and 3/6/14, the blue binder was observed in the same shelf, with the front cover not clearly visible and a notice of location of the survey results was not observed in the facility. On 3/6/14, at 4:01 p.m., the facility social service director confirmed the usual placement of the survey results in the binder, and indicated they were not clearly visible to residents or visitors to review without asking facility staff.	F 167		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have	F 225	Upon learning of the incident from the surveyor,the Vulnerable Adult policy was implemented immediately including reporting of the incident to the Minnesota Department of Health, the Big Stone County Sheriff, Adult Protective Services, Ombudsman and the Administrator.	3/5/14

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F 225	Continued From page 2 had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the the facility failed to thoroughly investigate and immediately report to the administrator and state agency (SA), bruises of	F 225	Cont. from page 2 Internal investigation was initiated and a report made to the Administrator, Minnesot Department of Health, Ombudsman, and Big Stone County Sheriff's Department. The Vulnerable Adult Policy has been reviewed and up-dated. All new hires will be educated on the Vulnerable Adult policy during the orientation process.	3/5/14 3/27/14

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F 225	Continued From page 3 unknown origin for 1 of 3 residents (R21) in the facility. Findings include: On 3/3/14, at 4:05 p.m., R21 was observed seated in her wheelchair, in her room, with a blanket covering her lap. A large dark purple colored bruise, was observed on R21's left hand. The bruise covered the entire top surface of the hand, from the base of the fingers to the wrist. R21's significant change Minimum Data Set (MDS) dated 11/28/13, identified R21 had diagnoses which included dementia, Alzheimer's disease and left sided hemiplegia (total or partial paralysis of part of the body). The MDS identified R21 was rarely/never understood, had short and long term memory problems, and had severely impaired cognitive skills for daily decision making. Further, the MDS identified R21 required extensive staff assistance for all areas of daily living (ADL). The corresponding Care Area Assessment (CAA) identified R21's self performance for bed mobility was "total dependence," mode of transfer was" lifted mechanically." The CAA further identified R21 had a vision and hearing deficit, was unable to speak, and "unable to communicate her needs." Review of R21's care plan revised 2/24/14, identified R21 was at risk for physical and verbal abuse by others, with approach #3 "document all incidents of potential or actual abuse at the time of occurrence." During an interview on 3/5/14, at 2:04 p.m. nursing assistant (NA)-B confirmed she was aware R21 had the bruise on the left hand since	F 225	A Meeting will be held for all staff April 3rd, 4th & 9th 2014. Topics to be presented during these meetings include, but may not be limited to: Review of the up-dated Vulnerable Adult Policy and also the Elder Justice Act. Reporting of Vulnerable Adult incidents, including how and where and when. Completion of an Event Report in Matrix. The Vulnerable Adult training on NetLearning (education and competency evaluation) will be completed by all staff who have not yet completed it already for this calendar year by 4/15/14 By 4/12/14 all Licensed staff and Department Managers. Will have completed hands-on training and competency evaluation in filing a Vulnerable Adult Incident Report with Minnesota Department of Health. Daily monitoring X 30 days by Social Services, Director of Nursing, or designee via tracking log will be for any incident/event for compliance with the Vulnerable Adult policy and procedure. The results of this monitoring will be reviewed by the Quality Assurance Committee for further monitoring recommendations.	4/15/14

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F 225	Continued From page 4	F 225		

the previous weekend. NA-B stated the bruise would have been reported to a nurse at that time. NA-B confirmed the nurse would then complete the rest of the process with the bruise but was not sure what that entailed.

During an interview on 3/5/14, at 2:06 p.m. licensed practical nurse (LPN)A stated the bruise was "3 or 4 days old" and confirmed she had seen the notation of R21's bruise on the report sheet. LPN-A confirmed she did not know how R21 received the bruise, further stating the person who saw the bruise first would complete the report.

Review of progress notes dated 12/07/14, through 3/5/14, lacked documentation regarding R21's large area of bruising on the hand. Review of an untitled form, nursing staff referred to as the "report sheet," dated the 28th, identified R21 had a bruise on the left hand.

On 3/5/14, at 2:04 p.m. LPN-A confirmed the report sheet which identified R21's bruise on the 28th was the report sheet from the previous week and further stated the director of nursing (DON) was responsible to complete the investigation of how R21 received the bruise.

During an interview on 3/5/14, at 2:22 p.m. the assistant director of nursing (ADON) confirmed R21 was confused, and did not answer questions consistently. She indicated R21 was unable to independently move her left hand, was not aware R21 had sustained a large bruise on her left hand and was not aware of the cause of the bruise. The ADON confirmed no further reporting, documentation, or investigation had been completed for the bruise on the back of R21's left

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F 225	Continued From page 5	F 225		

hand. The ADON confirmed the usual facility practice for all resident bruising was as follows: The first staff (usually a NA) that saw the bruise would report to the charge nurse. The charge nurse would fill out an event in the computer and notify the DON, if the bruise is large or suspected abuse, the DON, Administrator and licensed social worker (LSW) would be notified as soon as possible, however; this had not been followed in this case.

During an interview on 3/5/14, at 3:16 p.m. the LSW confirmed the current facility policy and confirmed he was responsible for coordination of the abuse prevention, policy and procedures for the facility. The LSW confirmed he had no knowledge of R21's large bruise on the left hand. The LSW confirmed R21's bruise had not been immediately reported to the administrator nor to the state agency. The LSW confirmed R21 would not be able to report the cause of her injury, and he was not aware what had caused the injury for R21. LSW confirmed a large bruise from an unknown source should have been immediately reported to the state agency.

During follow up interview on 3/6/14, at 3:59 p.m. the LSW confirmed an unexplained bruise or other injury without immediate explanation would "raise a red flag", and would require further investigation. If no information available to reasonable explain the injury, he would expect to proceed to report immediately to the administrator and immediately to the SA.

During an interview on 3/6/14, the ADON reported she had spoken to the nurse responsible for the hand written note "bruise lt (left) hand?" for R21 on the report sheet dated the 28th. The ADON

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F 225	Continued From page 6 confirmed the nurse stated after notification of the bruising, no further report or investigation had been completed. The facility policy titled Protection / Vulnerable Adult , reviewed 7/2010, identified any case of actual or suspected maltreatment or abuse shall be investigated and reported. The policy identified in Attachment A, resident care situations that were at risk for abuse included residents with communication disorders, required heavy nursing care and/or total dependence on staff. The facility policy identified "unexplained bruising." was included in the policy and procedure required timely investigation, to be immediately reported to the administrator and immediately reported to the state agency.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the the facility failed to implement their abuse prohibition policies to thoroughly investigate and report to the administrator and state agency, bruises of unknown origin for 1 of 3 residents (R21) in the facility. Findings include:	F 226	Upon learning of the incident from the surveyor,the Vulnerable Adult policy was implemented immediately including reporting of the incident to the Minnesota Department of Health, Big Stone County Sheriff's Office, Adult Protective Services, Ombudsman and the Administrator. Internal investigation was initiated and a report made to the Administrator, Minnesota Department of Health, Adult Protective Services, Ombudsman, and Big Stone County Sheriff. Meeting will be held for all staff April, 2014. Topics to be presented during these meetings include, but may not be limited to:Review of the up-dated Vulnerable Adult Policy and also the Elder Justice Act. Reporting of Vulnerable Adult incidents, including how and where and when.	3/5/14

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F 226	Continued From page 7 The facility policy titled Protection / Vulnerable Adult , reviewed 7/2010, identified any case of actual or suspected maltreatment or abuse shall be investigated and reported. The policy identified in Attachment A, resident care situations that were at risk for abuse included residents with communication disorders, required heavy nursing care and/or total dependence on staff. The facility policy identified "unexplained bruising." was included in the policy and procedure to require a report and investigation. On 3/3/14, at 4:05 p.m., R21 was observed seated in her wheelchair, in her room, with a blanket covering her lap. A large dark purple colored bruise, was observed on R21's left hand. The bruise covered the entire top surface of the hand, from the base of the fingers to the wrist. R21's significant change Minimum Data Set (MDS) dated 11/28/13, identified R21 had diagnoses which included dementia, Alzheimer's disease and left sided hemiplegia (total or partial paralysis of part of the body). The MDS identified R21 was rarely/never understood, had short and long term memory problems, and had severely impaired cognitive skills for daily decision making. Further, the MDS identified R21 required extensive staff assistance for all areas of daily living (ADL). The corresponding Care Area Assessment (CAA) identified R21's self performance for bed mobility was "total dependence," mode of transfer was" lifted mechanically." The CAA further identified R21 had a vision and hearing deficit, was unable to speak, and "unable to communicate her needs." Review of R21's care plan revised 2/24/14, identified R21 was at risk for physical and verbal	F 226	Cont. from page 7 Completion of an Event Report in Matrix. The Vulnerable Adult training on NetLearning (education and competency evaluation) will be completed by all staff who have not yet completed it already for this calendar year by 4/15/14 By 4/12/14 all Licensed staff and Department Managers. Will have completed hands-on training and competency evaluation in filing a Vulnerable Adult Incident Report with the Minnesota Department of Health. Beginning 4/14/14, daily monitoring X 30days by Social Services, Director of Nursing , or designee via tracking log will be for any incident/event for compliance with the Vulnerable Adult policy and procedure. The results of this monitoring will be reviewed by the Quality Assurance Committee for further monitoring recommendations	4/15/14

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abuse by others, with approach #3 "document all incidents of potential or actual abuse at the time of occurrence."

During an interview on 3/5/14, at 2:04 p.m. nursing assistant (NA)-B confirmed she was aware R21 had the bruise on the left hand since the previous weekend. NA-B stated the bruise would have been reported to a nurse at that time. NA-B confirmed the nurse would then complete the rest of the process with the bruise but was not sure what that entailed.

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During an interview on 3/5/14, at 2:22 p.m. the assistant director of nursing (ADON) confirmed R21 was confused, and did not answer questions

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consistently. She indicated R21 was unable to independently move her left hand, was not aware R21 had sustained a large bruise on her left hand and was not aware of the cause of the bruise. The ADON confirmed no further reporting, documentation, or investigation had been completed for the bruise on the back of R21's left hand. The ADON confirmed the usual facility practice for all resident bruising was as follows: The first staff (usually a NA) that saw the bruise would report to the charge nurse. The charge nurse would fill out an event in the computer and notify the DON, if the bruise is large or suspected abuse, the DON, Administrator and licensed social worker (LSW) would be notified as soon as possible, however; this had not been followed in this case.

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F 226	Continued From page 10 proceed to report immediately to the administrator and immediately to the SA. During an interview on 3/6/14, the ADON reported she had spoken to the nurse responsible for the hand written note "bruise lt (left) hand?" for R21 on the report sheet dated the 28th. The ADON confirmed the nurse stated after notification of the bruising, no further report or investigation had been completed.	F 226		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident bathroom toilets were in good repair and sanitary for 5 of 30 (R7, R9, R17, R20, R21) residents' bathrooms reviewed. Findings include: On 3/6/14, at 1:00 p.m., an environmental tour was done with Engineer (E)-A and the facility administrator. During the tour, the following was observed: In R7's bathroom, there was light brown stained caulking, approximately/2 inch (in) wide around the entire base of the toilet. In R9's bathroom, there was dark black, cracked caulking, approximately 1/2 in wide around the	F 253	The toilets in Residents rooms (R7, R9, R17, R20 & R21) will be removed and cleaned. The bathroom tile will be cleaned and repaired. The toilets will be re-installed and sealed. The toilets and tile will be monitored by housekeeping and maintenance through Preventative Maintenance check list monthly X3 months then quarterly. Tom Montonye Maintenance Supervisor will be responsible to see that the work is completed. The repair information will be submitted to the safety Committee and Quality Assurance Committee for review.	4/15/14

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F 253	Continued From page 11 entire base of the toilet In R17's bathroom, there was cracked, black stained caulking approximately 1/2 in wide around the entire base of the toilet. In R20's bathroom, there was cracked floor tiles at the rear of the toilet with chips missing, and 1/2 in of discolored black caulking around the entire base of the toilet. In R21's bathroom, there was 1/2 in of cracked caulking, discolored black, around the entire base of the toilet. On 3/5/14, at 1:18 p.m., E-A confirmed the bathrooms/toilet areas were uncleanable because of the black, cracked caulking around the toilets in R7, R9, R17, R20, and R21's rooms. E-A indicated it looked as if there was leaking around the toilet bases that had caused the cracked, discolored caulking which made the area uncleanable. E-A further stated he was not aware of the leak around the toilets, and it was possible re-installation or re-caulking would be necessary. E-A stated maintenance had done daily rounds of random resident rooms, however all rooms were not inspected routinely. He indicated facility staff were to submit a maintenance slip for any needed repairs and stated he was not aware of a request for repairs for the toilet areas. On 3/6/14, at 10:18 a.m., maintenance staff (M)-A stated daily rounds were completed by maintenance staff. M-A indicated the rounds included a walk through of resident rooms, checking for safety hazards and function of mechanical equipment such as fans or lights, however resident bathrooms are not routinely checked. The usual system for needed repairs, maintenance slips would be sent to the department by facility staff.	F 253		

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	245579	A. BUILDING _____ B. WING _____	03/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH GRACE HOME	116 WEST SECOND STREET GRACEVILLE, MN 56240

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F 253	Continued From page 12 The facility log for daily rounds by every facility department was reviewed. M-A confirmed the log was for the month of February. The log verified rounds were done and signed daily by the maintenance staff, however the log did not include what areas were inspected in resident rooms. On 3/6/14, at 9:38 a.m., E-A stated there were policies for preventive maintenance of facility equipment, however there was not a written facility policy for routine maintenance of bathroom fixtures.	F 253		
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.	F 356	The Nurse Staffing Information Policy and Procedure has been reviewed and updated. The form has been updated to include an Actual hour's worked column and we have removed the shifts time ranges from the form. Business office staff or Licensed staff are to initial off the form for accuracy of each shift. Nursing staff will be educated on the policy and procedure by 1:1 meetings, stand ups and scheduled meetings on April 3,4 & 9th Competency evaluations will be given following education. Compliance monitoring will be done daily X2 weeks following the April meetings and then weekly X2 weeks these results will be reviewed with the Quality Assurance Committee for further monitoring recommendations.	3/26/14 3/26/14 4/9/14

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F 356	Continued From page 13 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 observation, interview and document review, the facility failed to accurately post the required nursing staff information which included actual hours of shifts worked by each category of nursing staff and. In addition, the facility failed to post the required nursing staff daily, at the beginning of each shift. This had the potential to affect all 43 residents and visitors to the facility. During the facility tour on 3/3/14, at 1:20 p.m., the facility form titled, Daily Staffing Posting for Compliance W/44 CFR Part 483.30, was observed affixed to a bulletin board on the wall facing the facility dining room. The form had three horizontal sections. Each section identified shift time range, category of staff, a number of total hours per category and a column labeled with a per cent sign. The shift time ranges were identified as follows: Days-5:30 a.m. to 4:30 p.m. PM-2-10:30 p.m. Noc. 10p-7a The posting lacked identification of the actual shift hours worked by each category of nursing	F 356		

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F 356	Continued From page 14 staff directly responsible for resident care. Observations on 3/4, and 3/5/14 revealed the same form used for nursing staff posting. The postings had the correct dates, however lacked the actual shift hours worked per category of nursing staff. Review of staff posting for the previous 30 days revealed the same form which lacked actual shift hours worked. On 3/5/14, at 12:04 p.m., nursing assistant (NA)-A stated she was one of three people responsible for the nursing staff posting. NA-A stated the usual practice for the posting of nursing staff hours was to check for any ill calls from nursing staff then change the posting to reflect the change. NA-A indicated the nursing information was posted once a day, and indicated there was not a person designated to update the posting each shift after the facility business office was closed for the day at 4:30 p.m. NA-A further stated if there were changes in nursing staff after business hours, the changes would be completed the next morning. NA-A stated on weekends the form is posted on Friday for Saturday and Sunday, and any necessary adjustments to the nursing hours worked on the weekend were made on Monday morning. NA-A confirmed there was no staff trained to adjust or maintain the nursing staff posting on evenings, nights or weekends. A facility policy titled, Nurse Staffing Information, approved 10/09, included direction to post total number and actual hours worked by licensed and unlicensed direct care staff on a daily basis. The requirements of the policy further directed the data would be posted daily for each shift.	F 356		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=F	Continued From page 15 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	A Resident Infection Log will be kept electronically and was placed in a shared file allowing either nurses station access. This log includes; resident identification, symptom of infection, location of infection, specific organism, antibiotic use, location of the resident, comments/follow up. Employee infection control tracking forms will be reviewed with all staff by 1:1, stand up and or scheduled meetings on April 3rd, 4th and 9th 2014. Employee illnesses will be tracked per the Employee Illness report. Tracking of Resident infections and Employee illnesses will be done weekly by the infection control coordinator, DON, or designee. Quarterly these results will be reviewed with the Quality Assurance Committee.	3/28/14 4/9/14

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F 441	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to implement an ongoing infection control surveillance program to identify and prevent infections, including tracking and trending resident infections and employee illnesses in the facility. This deficient practice had the potential to affect all 43 residents residing in the facility. Findings include: Review of infection control logs dated 1/8/14 through 2/25/14, identified the logs were computer entries in resident files. Review of the form titled Fourth Quarter Infection Control Report, dated 2013, identified licensed practical nurse (LPN)-B's review of October, November and December resident infections treated by antibiotics. The report lacked identification of the individual resident, symptoms of infection, location of infection, specific organism, antibiotic use, and location of resident to determine any patterns or trends in the facility. A graph of monthly urinary tract infections (UTI) per month documented the percent of UTI's per month. However the review did not document the infectious organism, or similarities of the infections. In addition, the documentation did not include tracking or trending of staff illness or infections. During an interview on 3/4/14, at 3:41 p.m. LPN-B confirmed she was the designated person with the responsibility of infection control coordinator. LPN-B identified the monitoring of resident infections began with an order including an antibiotic, or anti- fungal cream. The infection	F 441		

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F 441	Continued From page 17	F 441		

control report then was started in Matrix (a medical computer program). LPN-B identified the infection control report was completed as medications were ordered, and was a form with questions that staff answered regarding the infection. LPN-B identified approximately every two weeks she reviewed medication orders to ensure all infection reports were completed. LPN-B confirmed the computer system logs the infections in order to be able to look at what infections have been treated in the facility in the previous month. LPN-B confirmed, quarterly a report was printed, infections reviewed and the information was brought to the quality assurance meetings. LPN-B confirmed infection notes could be printed by resident, however; for specific infectious organisms, each individual medical record would need to be reviewed, and she completed this review quarterly. LPN-B confirmed she periodically reviewed general information regarding resident infections, however, did not track or trend staff illness, looking for any correlation to resident infections in the facility. She stated a hospital staff member tracked staff illnesses, and the two did not compare or correlate information. LPN-B stated she did not analyze infections on an ongoing basis, and confirmed the facility did not have an ongoing resident and staff infection control surveillance program.

During an interview on 3/4/14, at 4:17 p.m. the director of nursing (DON) confirmed LPN-B was the facility chair person of infection control and a hospital staff member was responsible of all hospital and nursing home staff illnesses. The DON confirmed she had been unaware that ongoing monitoring and review of resident and staff illness / infection had not been completed on

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F 441	Continued From page 18 an ongoing basis. The facility policy titled Infection Control Policies, reviewed 12/2012, page 2, identified the Infection Control Coordinator will collect, review, and analyze the information regarding all infections.	F 441		
F 466 SS=C	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to ensure potable and non-potable water needs for the facility were estimated and planned for, should loss of normal water supply occur. This had the potential to affect all 43 residents residing in the facility. Findings include: The facility's emergency water supply contract dated 12/11/2012, was reviewed. The contract identified 65, 5 gallon jugs of water would be delivered to the facility within 24 hours, for facility and hospital use. The contract lacked a method for storage, distribution, and the water or calculations for estimating the gallons of water required daily to meet the needs of the residents and staff should there be loss of the water supply in an emergency.	F 466	The current Policy and will be updated by 4/12/14 to include water quantity estimate based on season, residents and support staff served. Policy will also be updated to include water availability from contractor based on need and distribution method. Policy will be reviewed annually for quantification of need. Administration will be responsible to see that the work is completed. The policy will be submitted to the safety and Quality Assurance Committees to further review and recommendations.	4/12/14

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F 466	Continued From page 19 During an interview on 3/4/14, at 2:51 p.m. the maintenance staff (M)B identified the 65, 5 gallon jugs would be used for this facility and the hospital needs. M-B stated this amount was a rough estimate decided upon in 2012, however the facility had not analyzed normal water consummation for the facility to determine possible needs for the facility. M-B confirmed a calculation had not used to determine the amount of water needed for the various facility water needs, and further identified no plan for distribution or storage of water was available. During an interview on 2/5/14, at 2:37 p.m., the administrator confirmed the current facility's emergency water policy did not contain specifications of how water would be distributed through out the facility nor were there calculations regarding how much total potable and non potable water would be needed in the event of a water emergency.	F 466		

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

F5579023

PRINTED: 03/24/2014
FORM APPROVED
OMB NO. 0938-0391

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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 CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Essentia Health - Grace Home 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	POC ok TS 4-8-14 RECEIVED APR - 4 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc: 4-15-14

Exit: 3-6-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature], CNHA	Administrator	3/31/14

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

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us 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. Essentia Health - Grace Home is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1976 and was determined to be of Type II(111) construction. In 1998, 3 additions were added to the southeast, northeast and northwest that were determined to be of Type II(111)construction. Because the original building and the addition meet the construction types allowed for existing buildings, the facility was surveyed as one building. The building is protected by a complete fire sprinkler system. The facility has a fire alarm system with smoke detection by the smoke barrier doors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 45 beds and had a census of 43 at the time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to properly identify 2 of 7 non-required doors leading to the exterior that do not lead to the public way in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.1.7 and 7.10.8.1 These deficient practices could negatively affect 6 of 45 residents, staff and visitors, by causing confusion in locating an exit from the building to the public way in the event of an emergency. Findings include: On facility tour between 11:00 AM and 2:00 PM on 03/05/2014, observations revealed that the 2 doors that leads to an enclosed courtyard from the northeast nurses station day room of the facility were not marked as "NO EXIT". These doors are not part of a required exit and need to	K 022	The 2 doors at the Northeast Nurses Station have been marked as "NOT AN EXIT" In 2" letters. Maintenance Supervisor was responsible to see that the work was completed. The repair information will be submitted to Quality Assurance Committee for review.	3/10/14

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K 022	Continued From page 3 display a sign that reads as follows: NO EXIT. The word "NO" shall be in letters 2 inches in height and with a stroke width of 3/8 inch, and the word "EXIT" in letters 1 inch in height located directly below the word "NO". This was confirmed by the Maintenance Manager (TM).	K 022		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that would affect all residents, visitors and staff of the facility. Findings include: On facility tour between 11:00 AM and 2:00 PM on 03/05/2014, observations reveled that the spare sprinkler head box was not equipped with at least 2 of every type and style of sprinkler	K 062	4 missing spare sprinkler heads have been replaced in the spare sprinkler head box. Maintenance Supervisor was responsible to see that the work was completed. The repair information will be submitted to the safety and Quality Assurance Committee for review.	3/18/14

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ESSENTIA HEALTH GRACE HOME	**116 WEST SECOND STREET GRACEVILLE, MN 56240**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 4 heads that are being used in the facility. The observed missing spare sprinkler heads were the 200 degree elevated temp head, high temp head that are used for the kitchen hood suppression system, 155 degree QR heads with a soldered link, and the 155 degree QR heads with the soldered pellet link. This was confirmed by the Maintenance Manager (TM).	K 062		
K 069 SS=D	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: Based on documentation review and staff interview, it was determined that the facility has failed to ensure that 2 of 2 cleaning and inspections of the kitchen hood system protecting the cooking appliances have been completed. NFPA 96 8-3.1 per table 8-3.1, states that for moderate-volume cooking operations, the hood system and components shall be inspected and maintained semiannually by a properly trained, qualified, and certified company or person. This deficient practice could affect 6 of 45 residents, all kitchen staff and visitors. Findings Include: On facility tour between 11:00 AM and 2:00 PM on 03/05/2014, during the review of all available documentation for the kitchen hood ventilation system inspection reports the facility could not provide any documentation showing that the	K 069	The kitchen hood is inspected annually and was last inspected 5/9/13. The hood cleaning will be added to Preventative Maintenance checklist Semi-annually. The hood will be cleaned by 4/14/14. Maintenance Supervisor will be responsible to see that the work is completed. The repair information will be submitted the the Quality Assurance Committee for review.	4/14/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245579	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/05/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ESSENTIA HEALTH GRACE HOME	**116 WEST SECOND STREET** **GRACEVILLE, MN 56240**

(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 5 kitchen hood/ventilation system has been completely cleaned and professionally inspected during the last 12 month time period. This was confirmed by the Maintenance Manager (TM).	K 069		

SimplexGrinnell BE SAFE.

Task # 36269630 Quarterly ☐ Annual X 3 Year ☐ 5 year ☐

25412468

REPORT OF SPRINKLER INSPECTION

Date May 9, 2013

CUSTOMER	Holy Trinity Hospital and Grace Home	INSPECTOR NAME	Kent Regelin
BUILDING / LOCATION		SIMPLEXGRINNELL OFFICE	SimplexGrinnell
STREET	115 W 2nd St		5400 Nathan Ln N Ste 100
CITY	Graceville STATE Mn ZIP 56240-4845		Plymouth, MN 55442-2128
ATTN:	Tom	PHONE #	763-367-5000 800-292-4111
PHONE #	320-748-7223 320-818-6652	LICENSE #	J1025

1. GENERAL (To be answered by Customer.)

	YES	NA	NO
a. Have there been any changes in the occupancy classification, machinery or operations since the last inspection?			X
b. Have there been any changes or repairs to the fire protection systems since the last inspection?			X
c. If a fire has occurred since the last inspection, have all damaged sprinkler system components been replaced?		X	
If answered "yes" to a, b or c, list changes in Section 13.			
d. Has the piping in all dry systems been checked for proper pitch within the past five years?		X	
Date last checked: _____ (check recommended at least every 5 years)			
e. Has the piping in all systems been checked for obstructive materials?	X		
Date last checked: 10-28-10 (check required at least every 5 years)			
f. Have all fire pumps been tested to full capacity using hose streams or flow meters within the past 12 months?		X	
g. Are gravity, surface or pressure tanks protected from freezing?		X	
h. Standard sprinklers 50 years old or older? ☐ QR (20yr) ☐ Dry (10 yr) ☐ 325F/163C (5yr) ☐ Corrosive env't. (5yr.)			X
(Testing or replacement required for these types of sprinklers.)			
i. Are any extra high temperature solder sprinklers regularly exposed to temperatures near 300F/149C?			X
j. Have gauges been tested, calibrated or replaced in the last 5 years? Date 10/28/10	X		
k. Alarm valves and associated trim been internally inspected past 5 years? Date		X	
l. Check valves internally inspected in the last 5 years? Date 10/28/10	X		
m. Has the private fire main been flow tested in last 5 years? Date		X	
n. Standpipe 5 year requirements.			
1. Dry standpipe hydrostatic test Date		X	
2. Flow test Date		X	
3. Hose hydrostatic test Date		X	
4. Pressure control valve test Date		X	
5. Pressure reducing valve test Date		X	
o. Have pressure reducing valves been tested at full flow within the past 5 years? Date		X	
q. Have master pressure reducing valves been tested at full flow within the past 1 year?		X	
r. Have the sprinkler systems been extended to all areas of the building?		X	
s. Are the building areas protected by a wet system heated, including its blind attics and perimeter areas?	X		
t. Are all exterior openings protected against the entrance of cold air?	X		

2. CONTROL VALVES

a. Are all sprinkler system main control valves and all other valves in the appropriate open or closed position?	X		
b. Are all control valves sealed or supervised in the open position?	X		

Control Valves	# of Valves	Type	Easily Accessible		Signs		Valve Open		Secured? If Yes, How?		(Sealed?) (Locked?) (Supvd.?)	Supervision Operational	
			YES	NO	YES	NO	YES	NO	YES	NO		YES	NO
CITY CONNECTION													
TANK													
PUMP													
SECTIONAL	Hosp.-1	Butterfly	X		X		X		X		Supervised	X	
SYSTEM	Hosp.-1	OS&Y	X		X		X		X		Supervised	X	
ALARM LINE	Hood	Butterball	X		X		X		X		Supervised	X	
Grace Home	1	OS&Y	X		X		X		X		Supervised	X	

Location of Control Valves:

Hood system is in Grace Home.

REPORT OF SPRINKLER INSPECTION

3. WATER SUPPLIES

a. Water supply sources? City: ☑ Gravity Tank: ☐ Pressure Fire Pump & Tank ☐ Pressure Fire Pump & City ☐ Pressure Fire Pump & Pond ☐

Main Drain Test Results Made During This Inspection

Test Pipe Located	Size Test Pipe	Static Supply Pressure Before	Residual Pressure	Return time to Static Pressure	Test Pipe Located	Size Test Pipe	Static Supply Pressure Before	Residual Pressure	Return time to Static Pressure
Hospital Riser	2"	70	35	56					
Grace Home Riser	2"	65	47	63					

4. TANKS, PUMPS, FIRE DEPT. CONNECTIONS

	YES	NA	NO
a. Do fire pumps, gravity, surface or pressure tanks appear to be in good external conditions?		X	
b. Are gravity, surface and pressure tanks at the proper pressure and/or water levels?		X	
c. Has the storage tank been internally inspected in the last 3 yrs. (unlined) or 5 yrs. (lined)? Date:		X	
d. Are fire dept. connections in satisfactory condition, couplings free, caps or plugs in place and check valves tight?	X		
e. Are fire dept. connections visible and accessible?	X		

5. WET SYSTEMS

	YES	NA	NO
a. No. of systems: 2 Make, Model, & Size: 4"			
b. Are cold weather valves in the appropriate open or closed position?		X	
If closed, has piping been drained?		X	
c. Has the Customer been advised that cold weather valves are not recommended?		X	
d. Have all the antifreeze systems been tested? Date:		X	
The antifreeze tests indicated protection to: (Note temp & type for each. Example: -15F/-26C glycol or -15F/-26C glycerin)			
System 1) 2) 3)			
4) 5) 6)			
Did alarm valves, water flow alarm devices and retards test satisfactorily?	X		

6. DRY SYSTEMS

	YES	NA	NO
a. No. of systems: N/A Make, Model, & Size:			
Date last trip tested: ☐ Partial ☐ Full			
b. Are the air pressure and priming water levels normal?		X	
c. Did the air compressor operate satisfactorily?		X	
d. Air compressor oil checked? ☐ Belt? ☐			
e. Were Auxiliary / Low Point drains drained during this inspection? No. of Drains:		X	
Locations 1) 2)			
3) 4)			
f. Did all quick opening devices operate satisfactorily? Make: Model:		X	
g. Did all the dry valves operate satisfactorily during this inspection?		X	
h. Is the dry valve house heated?		X	
i. Do dry valves appear to be protected from freezing?		X	

7. SPECIAL SYSTEMS

	YES	NA	NO
a. No. of systems: 1 Make & Model, & Size: Wet Hood--Grace Home			
Type:			
b. Were valves tested as required?	X		
c. Did all heat responsive systems operate satisfactorily?		X	
d. Did the supervisory features operate during testing?	X		
e. Has a supplemental test form for this system been completed and provided to the customer? (Please attach)		X	

Auxiliary equipment: No. Type:

Location

Test results

8. ALARMS

	YES	NA	NO
a. Did the water motors and gong operate during testing?		X	
Did the electric alarms operate during testing?	X		
c. Did the supervisory alarms operate during testing?	X		

REPORT OF SPRINKLER INSPECTION

9. SPRINKLERS - PIPING	YES	NA	NO
a. Do sprinklers generally appear to be in good external condition?	X		
b. Do sprinklers generally appear to be free of corrosion, paint, or loading and visible obstructions?			X
c. Are extra sprinklers and sprinkler wrench available on the premises? (#, size, finish, temp, brand, of spare heads)	X		
d. Does the exposed exterior condition of piping, drain valves, check valves, hangers, pressure gauges, open sprinklers and strainers appear to be satisfactory?	X		
e. Does the hand hose on the sprinkler system appear to be in satisfactory condition?		X	
f. Does there appear to be proper clearance between the top of all storage and the sprinkler deflector?	X		

10. EXPLANATION OF "NO" ANSWERS AND DEFICIENCIES. (Sections 1d thru 9):

Items stored in hospital basement blocking sprinkler heads. 18" clearance, on a horizontal plane, should be maintained between sprinkler heads and stored items.

11. THE INSPECTOR SUGGESTS THE FOLLOWING NECESSARY IMPROVEMENTS. THESE SUGGESTIONS ARE NOT THE RESULT OF AN ENGINEERING SURVEY AND DO NOT REFLECT CONDITIONS ABOVE CEILINGS OR IN CONCEALED SPACES:

12. ADJUSTMENTS OR CORRETIONS MADE:

13. LIST CHANGES IN OCCUPANCY, HAZARD OR FIRE PROTECTION SYSTEM, AS ADVISED BY CUSTOMER IN SECTION 1 a-c:

14. INSPECTION DEFICIENCIES AND SUGGESTED IMPROVEMENTS WERE DISCUSSED WITH THE CUSTOMER /CUSTOMER REPRESENTATIVE. YES ☐ NO ☐

If No, explain.

IMPORTANT NOTICE TO CUSTOMER Customer acknowledges and agrees that, in the absence of a Service Agreement between the parties, services hereunder are performed pursuant to the terms and conditions of this Report, agrees that the services have been completed to Customer's satisfaction and that the system is in good working order and repair, unless services performed were of a temporary nature, in which case Customer acknowledges that part of customer's system may have been bypassed or is otherwise inoperable until service can be completed. **CUSTOMER'S ATTENTION IS DIRECTED TO THE LIMITATION OF LIABILITY, WARRANTY, INDEMNITY AND OTHER CONDITIONS AT THE REVERSE SIDE/END OF THIS REPORT.** This Agreement has been drawn up and executed in English at the request of and with the full concurrence of Customer. Ce contract a été rédigé en anglais à la demande et avec l'assentiment du client.

CUSTOMER SIGNATURE		
05/09/2013 10:47:56 am	Tom Montonye	05/09/2013 10:47:56 am Kent Regelin

DUPLICATE TO: Some AHJ's may require a copy of annual inspections be sent to them.
STREET: If your AHJ has made this request of us, then we will be sending in a copy.
CITY, STATE AND ZIP:
ATTN: