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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 84FV

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)

6. DATE OF SURVEY **06/21/2017** (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 **56** (L18)
13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(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):

17. SURVEYOR SIGNATURE — Date :
Sue Reuss, Unit Supervisor — 07/14/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Certification Specialist — 07/25/2017 (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 07/27/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/28/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245554 July 14, 2017

Ms.. Tamara Borstad, Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, MN 56284

Dear Ms.. Borstad:

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 June 26, 2017 the above facility is recommended for:

56 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 14, 2017

Ms.. Tamara Borstad, Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, MN 56284

RE: Project Number S5554028

Dear Ms.. Borstad:

On May 22, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 4, 2017 that included an investigation of complaint number . 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 June 21, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 26, 2017 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 May 4, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 26, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 4, 2017, effective June 26, 2017 and therefore remedies outlined in our letter to you dated May 22, 2017, 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.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 84FV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00557

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(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 **05/04/2017** (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 **56** (L18)
13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(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):

17. SURVEYOR SIGNATURE Date :
Glenora Souther, HFE NE II 06/12/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/28/2017 (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:

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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
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 22, 2017

Ms. Tamara Borstad, Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, MN 56284

RE: Project Number S5554028

Dear Ms. Borstad:

On May 4, 2017, 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;

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street
Marshall, Minnesota 56258-2529
Email: kathryn.serie@state.mn.us
Phone: (507) 476-4233
Fax: (507) 344-2723

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 June 13, 2017, 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 June 13, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 August 4, 2017 (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 November 4, 2017 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC 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 electronic 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Please contact me if you have questions related to this eNotice.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING _____ B. WING _____	05/04/2017

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's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were in reach for 1 of 2 residents (R40) reviewed for call light concerns. Findings include: R40's Face Sheet printed 5/4/17, identified diagnosis that included chronic obstructive pulmonary disease (COPD), unspecified arthritis,	F 246	1) Call light placement for R40 was assessed and another call light was placed in R40□s room next to his recliner on 5/1/17 to ensure he had a call light within reach, whether he was in his bed or his recliner. 2) All residents have the potential to be affected by this. All residents who are not independent in their room will be assessed for call light placement to	6/7/17

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

Electronically Signed | 05/31/2017

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 _____	05/04/2017

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 246	Continued From page 1 and glaucoma. R40's annual Minimum Data Set (MDS) dated 2/13/17, indicated R40 had mild cognitive impairment, required one person assist to move between locations in his room, and needed staff assist for transfers and toileting. R40's care plan dated 4/15/17, directed to keep call light in reach. R40's Annual Assessment report dated 2/10/17, identified R40 had deformity of ankles, but was able to ambulate with walker and assist of one. The assessment indicated R40 was at moderate risk for falls. On 5/1/17, at 4:15 p.m. R40 was observed in his room seated in his recliner by the window. R40's call light was observed to be on the bed, approximately 6 feet from the chair. On 5/1/17, at 4:35 p.m. licensed practical nurse (LPN)-A stated that R40 used the light at night. LPN-A acknowledged the call light should be within his reach. On 5/1/17, at 6:56 p.m. the DON verified R40 should have a call light within reach. The policy Call Light dated 3/25/11, directed staff to position the call light within the resident's reach.	F 246	ensure they are able to reach their call light. 3) All staff will be educated on proper call light placement to ensure all residents have access to their call light to call for assistance. 4) Call light placement audits will be completed on 6 random residents 2x/week for 4 weeks, then 6 random residents weekly for 2 months. Audit results will be brought to QA monthly for further recommendations. 5) DON or designee will be responsible	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 278		6/7/17

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 _____	05/04/2017

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 278	Continued From page 2 (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accurately code the Minimum Data Set for transfers and pressure ulcers, for 1 of 1 residents (R16) reviewed for pressure ulcers.	F 278	1) R16□s MDS with ARD of 4/3/17 reviewed and modifications to section G and section M were made to MDS on 5/24/17 2) All residents are required to have assessments and MDS□s completed,	

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F 278	Continued From page 3 Findings include: R16's significant change Minimum Data Set (MDS) dated 4/3/17, indicated R16 required extensive assistance (resident involved in activity, staff provided weight bearing support) with transfers. The MDS also indicated R16 did not have any pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). On 5/3/17, at 8:00 a.m. nursing assistant (NA)-C and NA-E were observed transferring R16 from a wheel chair to the commode with a mechanical lift. When R16 was done on the commode, NA-C and NA-E transferred R16 to bed with a mechanical lift and completed cares on R16. When done, NA-C and NA-E transferred R16 to her wheel chair with the mechanical lift. R16 required total assist for this transfer. On 5/3/17, at 9:58 a.m. trained medication aide (TMA)-B offered to toilet R16. During observation TMA-B assisted NA-E to transfer R16 using a mechanical lift. R16 required total assist for this transfer. On 5/3/17, at 12:59 p.m. R16 was observed being transferred from the wheel chair to the bed with a mechanical lift by TMA-B and NA-E. R16 required total assist for this transfer. On 5/4/17, at 10:19 a.m. registered nurse (RN)-B was interviewed. RN-B stated coding on R16's MDS regarding transfers should have been coded as total assistance (full staff performance every time during seven day period). RN-B stated, " I have a mistake on the MDS. I need to do a	F 278	therefore, all residents have the potential to be affected by this. 3) MDS nurse will be educated on ensuring ADL status and skin status is coded correctly and assessment is completed accurately. 4) MDS audits for accuracy of Section G and M will be completed on All residents with MDS□s completed in the next 30 days , then 2 records per week x2 weeks, then 1 record per week for 2 months. Audit results will be brought to QA monthly for further recommendations. 5) DON or designee will be responsible	

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correction."

A Skin Condition/Wound Progression note dated 3/28/17, indicated an open blister was present on R16's coccyx. The following findings were documented Staging : Stage 1 (Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area).

On 5/3/17, at 1:08 p.m. RN-A stated she would classify the Stage 1 pressure ulcer as a partial thickness oval wound, not a pressure ulcer. RN-A state she would not call it a pressure ulcer because it was caused by friction. RN-A stated the pressure ulcer was first observed on 4/5/17. RN-A reviewed the facility policy on pressure ulcers, and then stated she would call it a pressure ulcer, "[R16's] wound was probably caused by friction and moisture, and that is part of the definition of a pressure ulcer. That wound is over the coccyx /sacrum area and they are bones."

On 5/4/17, at 11:04 a.m. RN-B verified an open blister is not a Stage 1 pressure ulcer, it is a Stage 2 (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister). Length in cm: 1.5 cm. Width in cm: 1.5 cm. Skin is blanchable, no odor is apparent, no drainage apparent. pressure ulcer. RN-B verified R16's MDS lacked indication of a pressure ulcer, and there was no documentation indicating why it was not coded as such. RN-B stated, "I probably should have documented it as a Stage 2."

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F 278	Continued From page 5 On 5/4/17, at 11:55 a.m. the director of nurses (DON) stated the MDS should accurately reflect what is in the chart. The facility policy MDS 3.0 Assessments reviewed/amended 5/11/15, directed staff to conduct a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI [Resident Assessment Instrument] manual and regulations, Rules and Status specified by the Centers for Medicare and Medicaid and the State of Minnesota.	F 278		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management.	F 309		6/7/17

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F 309	Continued From page 6 The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify bruising for 1 of 3 residents (R16) reviewed for non-pressure related skin conditions. Findings include: R16's significant change Minimum Data Set (MDS) dated 4/3/17, indicated R16 had mild cognitive impairment, and required staff assistance with activities of daily living (ADLs). The MDS also indicated R16 had diagnoses of heart failure and weakness. R16's Physician Order Sheet signed 4/11/17, indicated R16 was on aspirin 81 milligrams (mg) every day. On 5/1/17, at 5:44 p.m. R16's right elbow was observed to have a large fading bruise. On 5/03/17, at 8:00 a.m. R16's morning cares were observed being completed by nursing assistant (NA)-C and NA-E. When R16's gown was removed, there was a bruise on the left	F 309	1) R16□s skin and wound report was updated with her skin concern of bruising on 5/3/17. Measurements were completed and documented on 5/3/17 and monitoring put into place on treatment record to monitor bruising until healed. 2) All residents have the potential to be affected by this. Skin audits will be completed on all residents. 3) All staff will be educated on identifying and reporting any bruise that is observed on a resident. 4) Skin audits on 4 random residents will be completed 2x/week for 1 month, then 4 random residents weekly for 2 months. Audit results will be brought to QA monthly for further recommendations. 5) DON or designee will be responsible	

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upper arm, and a bruise on the right arm. NA-E asked NA-C, "Do they know about bruises on her arms?" NA-C did not respond. R16 was dressed in a short sleeve shirt with a sweater draped over shoulders and slacks. When done getting dressed, NA-C took R16 to the dining room.

On 5/30 17, at 12:59 p.m. R16 was transferred from wheel chair to bed by trained medication aide (TMA)-B and NA-E. Registered nurse (RN)-A looked at R16's skin and verified bruises were present on both elbows.

R16's care plan dated 1/9/17, indicated R16 was on comfort cares. The care plan also indicated R16 at risk for altered skin integrity, and directed staff to inspect skin weekly, monitor skin, and report changes to nurse. R16's care plan also indicated R16 bruised easily with any little bump and refused arm protectors or long sleeves.

An undated and unlabeled Team Assignment Sheet for R16 did not address bruising.

On 5/3/17, R16's bruises were measured RN-A. The bruise located on resident's upper left bicep measured 2 centimeters (cm) x 2.5 cm and was dark purple in color. The bruise on R16's left lower back forearm measured 1 cm x 2.5 cm. Two bruises on R16's right lower back forearm each measured 1.5. cm x 1.5 cm.

On 5/3/17, at 1:34 p.m. NA-E stated R16 bruised easily. NA-E stated she did not tell the nurse about R16's bruises, because she assumed they knew about them because they were visible.

On 5/4/17, at 8:00 a.m. trained medication aide (TMA)-B stated she had worked with R16 on

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Monday and Wednesday. TMA-B said she had observed R16's bruises, but thought someone else had reported them. TMA-B stated R16 bruised easily.

On 5/4/17, at 8:43 a.m. registered nurse (RN)-A stated the facility did not have measurements of the bruises until today. RN-A stated all bruises should be measured weekly. RN-A further stated she had measured R16's bruises, and interviewed her. R16 told RN-A her doctor told her that her skin bruises very easily, and sometimes she bumps her arms. RN-A stated R16 refused the idea of wearing her sweater, saying she did not want anything on her arms. RN-A stated, "I expect that they [staff] verify with me that it [bruise or wound] had already been reported. I expect that staff let me know if getting worse. Everybody can monitor, licensed staff are expected to chart on them daily." RN-A verified neither NA-A or NA-C reported the bruises.

On 5/4/17, at 1:15 p.m. NA-F stated she worked day and evening shifts. NA-F further stated she saw the bruises Monday and Tuesday, but didn't inform the nurse, "I thought they knew. You could see them easily."

On 5/4/17 at 11:55 a.m. the director of nurses (DON) stated the facility process when a bruise is found is to do an incident report, notify family, the doctor, and put monitoring into the E-TAR (electronic treatment record) until the bruise is healed. The DON stated the bruise should be monitored one to two times a day. The DON stated staff should discontinue the order when the bruise is healed. The DON further stated a bruise should be reported when it is found, but no later than the end of shift. The DON verified staff

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F 309	Continued From page 9 should have notified the RN about R16's bruises. " A policy for monitoring and documenting of bruises was requested but not provided.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, monitor, and treat pressure ulcers in order to heal current pressure ulcers and prevent the development of new pressure ulcers for 1 of 1 resident (R16) who developed pressure ulcers while residing in the facility. Findings include: Pressure ulcer stages as defined by the National	F 314	1) R16□s skin and wound report was reviewed and updated related to open area on coccyx. R16□s primary MD was asked to come to the facility on 5/5/17 and a complete assessment of R16□s skin and overall status was completed. Measurements were completed and documented on 5/6/17. Root Cause Analysis completed on current open area. 2) All residents with current skin concerns have the potential to be affected	6/7/17

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F 314	Continued From page 10 Pressure Ulcer Advisory Panel (NPAUP): Stage I: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. R16's significant change Minimum Data Set (MDS) dated 4/3/17, indicated R16 had mild cognitive impairment, required staff assistance with activities of daily living, and indicated R16 had diagnoses of heart failure and weakness. The MDS also indicated R16 had no current pressure ulcers, was at risk for the development of pressure ulcers, and had moisture associated skin damage. The MDS further indicated R16 had a pressure reducing device for chair, and was on a turning and repositioning program. R16's care plan dated 1/9/17, indicated R16 was on comfort cares. The care plan identified R16 required assistance with bed mobility, slept in a recliner, and was to be repositioned every two hours in the recliner. The care plan further directed staff to check R16 for incontinence every two hours, and monitor skin for red areas and report to the nurse. The care plan also directed R16 was to be turned and repositioned every two hours to help prevent skin breakdown, R16 required a pressure relieving cushion in her wheelchair and recliner, and staff was to	F 314	by this. Residents with current skin and wound reports involving an open area will be reviewed to ensure accurate assessment is completed. 3) Staff will be educated on ensuring any skin concerns are addressed with accurate assessment of the concern. 7) Skin and wound report audits on 4 random residents will be completed 2x/week for 1 month, then 4 random residents weekly for 2 months. Audit results will be brought to QA monthly for further recommendations. 4) DON or designee will be responsible	

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administer barrier cream to buttocks twice a day and with each incontinent episode. The care plan lacked identification of R16's open areas on her buttocks.

R16's Physicians Order sheet signed 4/11/17, instructed staff monitor open area on resident's upper coccyx area. Cover with Mepilex (a foam dressing) and change two times a day and as needed. Orders also instructed staff to monitor buttocks every shift for healing. Notify doctor if not healing. Ensure Mepilex intact on sacrum and left side of buttocks. Replace if soiled or comes loose.

A progress note dated 4/4/17, labeled assessment for SCSA (significant change in status assessment) ARD (assessment reference date) 4/3/17, indicated R16 was dependent on staff for transfers, and needed extensive assistance for bed mobility, toileting and personal hygiene. R16 had no use of left upper extremity, and was unable to walk or stand. R16 was admitted with an open area on her coccyx which was currently being treated. A new cushion was to be tried in the recliner and wheelchair. Nursing initiated a pressure relieving cushion for recliner and wheelchair. R16 had a Braden (pressure ulcer risk assessment) score of 13 indicating R16 was at moderate risk for pressure ulcer development. R16's Tissue Tolerance Testing indicated R1 could sit or lie in one spot a maximum of two hours and required repositioning or offloading at least every two hours R16 went from wheelchair to recliner throughout the day and stated she did not wish to be repositioned, just wanted to sit in her recliner and did not want to be awakened at night.

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An undated and unlabeled Team Assignment Sheet for R16 directed staff R16 required extensive assist of 2 to assist with boosting and repositioning. The sheet also directed staff to apply barrier cream to coccyx twice daily and with each incontinence episode, a black cushion was to be used in the recliner and blue cushion used in the wheelchair. The sheet further directed R16 was to be repositioned every 2 hours sitting and offloaded as R16 tolerated during repositioning. The sheet indicated R16 refused to be toileted and repositioned and directed staff to explain the importance of repositioning and toileting.

Skin condition/Wound progression notes from 1/5/17, through 5/4/17, revealed the following:

Coccyx: 1/5/17: an abrasion present on admission 1 centimeters (cm) x 0.5 cm. 1/12/17: described as worsening. 1/24/17: wound was healed. 1/27/17: very small area that is slightly open. 1/30/17: new coccyx wound described as a slit 0.5 cm in length. 2/6/17: area was healed. 2/23/17: open lesion 0.3 cm with minimal drainage. 3/2/17: open lesion changed to moisture associated skin damage. Dressing in place. 3/25/17: skin is reddened and thin but healing. 4/4/17: area was healed. 3/28/17: new coccyx wound presented as an open blister. Stage 1. Length 1.5 cm, width 1.5 cm. The wound was not present on admission. 4/4/17: healing. No further documentation was noted for the pressure ulcer on the coccyx.

Right lower buttock abrasion: 3/9/17: new right lower buttock abrasion underneath right gluteal fold measured 1.4 cm x 0.4 cm. Source: strap on bath seat in tub room. 4/4/17: right lower buttock abrasion healed. 4/5/17: new right lower buttock

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abrasion that measured 1.1 cm. x 1 cm. Dressing intact. 5/3/17: indicated the right lower buttock had an abrasion. No measurements were documented. The location was not consistent with inter gluteal cleft. 5/4/17: right lower buttock measurements 0.7 cm x 0.5 cm. The wound was superficial and was improving. The wound was not located on a bony prominence.

Left lower buttock: 1/30/17: new left lower buttock had a dry area that measured 1.3 cm x 0.5 cm. 2/27/17: area was healed. 3/16/17: new left lower buttock abrasion due to friction. Area measured 3 cm x 1 cm. The area was most likely caused from how resident is lifted mechanical standing lift. 4/4/17: area was healed.

A progress note dated 3/28/17, indicated, "Present on coccyx is a blister (open)." The following findings were also documented: Staging: Stage 1. Length in centimeters (cm) 1.5. Width in cm 1.5. Skin is blanchable, no odor is apparent, no drainage apparent. Recent changes were made to the treatment orders for this site. This would was not present on admission. General comments: noted 1.5 cm circular open blister on resident's coccyx. Covered with Mepilex dressing.

A progress note dated 4/6/17, indicated after healing all the skin issues on 4/4/17, and assessing on 4/6/17, R16's buttocks did not show any open areas. The intact Mepilex dressing was removed, and the skin under was clear. There was one remaining Opsite dressing at this area on her right lower buttock. The abrasion could be seen under the Opsite dressing. The Opsite dressing was left in place to prevent any disruption to to the skin integrity. The note further

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indicated the facility would continue to use barrier cream as needed, and would create a toileting plan to keep resident's skin as intact as possible.

A progress note dated 4/13/17, indicated risks and benefits for R16's non-compliance with toileting and incontinence cares was discussed with family and resident. A toileting plan was agreed upon.

A progress note dated 4/20/17, indicated R16's skin assessment was completed with no new redness or skin concerns noted at this time.

A progress note dated 4/27/17, indicated R16 was non-compliant with cares, and an open area on her coccyx remained open and was not healing due to non-compliance. R16's family wished she be kept comfortable.

A progress note dated 5/4/17, at 12:15 p.m. indicated an abrasion was present on R16's right lower buttocks. The wound was measured at 0.7 cm x 0.5 cm. The area was described as superficial, improving, and not located on a bony prominence. The facility was going to change pad type to see if the area improved.

On 5/3/17, at 8:00 a.m. R16's morning cares were observed being completed by nursing assistant (NA)-C and NA-E. Two small oval open areas were observed on R16's buttocks; one on the right buttock near the coccyx, and one on the left buttock near the coccyx. There was no dressing over the open areas. NA-E applied barrier cream to R16's entire buttock area. NA-E verified R16 had two open areas on her buttocks and stated, "They have been there a while. That is why we are using the barrier cream."

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F 314	Continued From page 15 On 5/3/17, at 9:58 a.m. R16's wheel chair cushion was observed. The gray foam three inch cushion did not have a cover on it. Bonded to the top of the foam cushion was a thin green gel-like sheet that had one inch circles rising from it. On top of the cushion was a small folded blanket, and 12 by 12 inch gray pillow on top of the folded blanket. The blanket did not cover the entire top of the cushion. Trained medication assistant (TMA)-B verified the foam cushion did not have a cover on it, but had a pillow and blanket on top of it. TMA-B stated the raised gel surface was to prevent R16 from slipping out of the chair. On 5/3/17, at 12:59 p.m. registered nurse (RN)-A observed R16's skin, and verified there were open areas on R16's right and left buttock. RN-A applied barrier cream to R16's bottom. On 5/4/17, at 8:43 a.m. RN-A measured the wounds on R16's buttocks. On the left buttocks near the coccyx measured 0.7 centimeters (cm) x 0.5 cm. The right buttock had two open areas: near the coccyx measured 2 cm x 0.5 cm, and on the outer buttock measured 0.8 cm x 1.5 cm. RN-A applied a Mepilex dressing to left buttock wound. No dressing was applied to right buttock wounds. On 5/3/17, at 1:08 p.m. RN-A was interviewed stated she would classify the Stage 1 pressure ulcer as a partial thickness oval wound, not a pressure ulcer. RN-A state she would not call it a pressure ulcer because it was caused by friction. RN-A stated the pressure ulcer was first observed on 4/5/17. RN-A stated the wounds were due to be measured the following day. RN-A verified the wounds were to be documented on weekly. RN-A	F 314		

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verified R16 should not to have the blanket and pillow over the cushion in the wheel chair because this changes the sitting surface, and reduces its effectiveness to reduce pressure, however this was a resident request. RN-A reviewed the facility policy on pressure ulcers, and then stated she would call it a pressure ulcer, "[R16's] wound was probably caused by friction and moisture, and that is part of the definition of a pressure ulcer. That wound is over the coccyx /sacrum area and they are bones."

On 5/3/17, at 1:34 p.m. NA-E stated R16 will often refuse to change positions, but is encouraged to get her up from recliner to chair or bed at least every 2 hours. NA-E stated R16 was often incontinent, and was resistive to being changed even when her clothing was wet with urine. NA-E stated, "[R16] would sit in wet clothing if we allowed it. We talk her out of it." NA-E verified R16 did not request blanket or pillow to be placed in the wheelchair. NA-E stated, "They were in the wheelchair so we left them there."

On 5/4/17, at 8:58 a.m. RN-A said, I would call it [wounds on right buttock] an excoriation or superficial area." RN-A reviewed computer documentation and said, "The abrasion might refer to one of these, but I don't have measurements for those [wounds on right buttock]. The left wound is on the cusp of the cheek. It is difficult to tell from the progress note because I do not have measurements." RN-A reviewed progress note date 4/5/17, at 1:48 p.m. and said, "It is probably for the left wound on the cusp." RN verified progress note date 4/5/17, at 1:48 p.m. was labeled right lower buttocks. RN-A reviewed progress note date 4/5/17, at 3:28 p.m.

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and said is for the two wounds on the right lower buttock.

On 5/4/17, at 11:04 a.m. RN-B verified an open blister is not a Stage 1 pressure ulcer, it is a Stage 2 (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister). Length in cm: 1.5 cm. Width in cm: 1.5 cm. Skin is blanchable, no odor is apparent, no drainage apparent. pressure ulcer. RN-B verified R16's MDS lacked indication of a pressure ulcer, and there was no documentation indicating why it was not coded as such. RN-B stated, "I probably should have documented it as a Stage 2."

On 5/4/17, at 11:55 a.m. director of nurses (DON) stated R16 did not have any pressure ulcers. The DON stated, "I have not seen her bottom. It could be an abrasion, moisture, trauma. I know the root cause the nurse identified was moisture associated skin damage." The DON stated staff always looked at tissue tolerance, incontinence level, the cushions and the actual positioning for each resident. The DON stated non-pressure areas and pressure ulcers were to be measured weekly. The DON verified R16's wounds were not measured weekly.

The facility policy Skin Ulcer Protocol updated 11/1/15, directed staff that residents will not develop pressure sores/skin ulcers unless it is clinically unavoidable and appropriate care and services will be provided t prevent, treat and monitor progress of all healing ulcer(s).
A. Abrasion-caused by shearing of skin from rubbing on rough surface or friction rubbing.
B. Definitions of Pressure Ulcer: Any lesion

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F 314	Continued From page 18 caused by unrelieved pressure resulting in damage to the underlying tissue(s), generally found over bony prominences and contributed to by shearing, friction, and /or moisture. Assessment and monitoring of skin concerns: daily documentation to address the following: An evaluation of the ulcer, if no dressing is present. An evaluation of the status of the dressing (intact, drainage, etc.). The status of tissue/area surrounding the ulcer (can be observed with dressing in place). The presence of possible complications, such as increasing size or infection. Wound Round documentation (weekly at a minimum) to include following: Type of wound, staging or classification, measurements, exudate (drainage), presence of pain, wound base tissue, description of wound edges and surrounding tissue, odor, wound specific charting, interventions in place, current treatment and response to treatment, and track wound status.	F 314		
F 334 SS=D	. 483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and	F 334		6/7/17

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F 334	Continued From page 19 potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 334		

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F 334	Continued From page 20 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure pneumococcal vaccinations were offered to 2 of 5 residents (R1, R48) whose immunization records were reviewed. In addition, the facility failed to implement policies related to guidelines for pneumococcal conjugate vaccine PCV13 as recommended by Centers for Disease Control (CDC). Findings include: The Center for Disease Control and Prevention dated 2/6/17, recommended "Adults who are immunocompetent and aged 65 years or older should receive 13-valent pneumococcal conjugate vaccine (PCV13) followed by 23-valent pneumococcal polysaccharide vaccine (PPSV23) at least one year after PCV13." Dated: Feb 6, 2017.	F 334	1) The Prevnar 13 vaccine was ordered on 5/4/17 for all residents wishing to receive the Prevnar 13 vaccine. Prevnar vaccine arrived on 5/10/17. R1 and R48 received the Prevnar 13 vaccination. 2) All residents with no documentation of receiving the Prevnar 13 pneumococcal vaccine have the potential to be affected by this. 3) Audits of all residents charts will be reviewed to ensure they have either received the vaccine and/or been offered the vaccine. 4) Chart audits on 4 random residents will be completed 2x/week for 1 month, then 4 random residents weekly for 2 months. Charts will be reviewed to ensure there is documentation that Prevnar 13 has been given and/or that it was offered. Audit results will be brought to QA monthly	

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F 334	Continued From page 21 R1's Face Sheet printed 5/4/17, indicated she was 84 years old, and admitted to the facility on 8/31/15. R1's immunization record indicated that no PCV13 had been administered since her admission to the facility. On 2/07/17, R1 signed the facility Pneumococcal Conjugate Vaccine PCV 13 (Prevnar) Information Sheet and Consent Form and indicated "Yes, I wish to receive the vaccine." On 2/15/17, R1's guarantor signed "Pneumococcal Conjugate Vaccine PCV 13 (Prevnar) Information Sheet and Consent Form that indicated "Yes, I wish to receive the vaccine." R48's Face Sheet printed 5/4/17, indicated she was 90 years old, and admitted to the facility on 2/19/15. The immunization record indicated that no PCV13 had been administered since her admission to the facility. On 1/23/17, R48 signed the facility Pneumococcal Conjugate Vaccine PCV 13 (Prevnar) Information Sheet and Consent Form and indicated "Yes, I wish to receive the vaccine." On 4/7/17, an agreement for the Medical Director Purchase and Possession of Tuberculin and Certain Vaccines was signed by the Medical Director, the director of nursing (DON) and registered nurse (RN)-C. The agreement indicated Renvilla Health Services may order, on the behalf of the medical director, tuberculin, hepatitis, influenza, tetanus and "any other vaccines as required by the Minnesota Department of Health." On 5/4/17, at 11:34 a.m. the DON stated they are in process of ordering Prevnar from the pharmacy. The DON verified not all residents had received the PCV 13. The DON verified consents	F 334	for further recommendations. 5) DON or designee will be responsible	

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F 334	Continued From page 22 were in the process of being obtained by RN-C. On 5/4/17, at 2:36 p.m. the DON stated it was her responsibility to order the Prevnar, and verified she had not yet ordered the individual vaccine doses. The facility Immunization Policy-Residents dated 3/1/17, directed pneumococcal vaccine will be offered to each resident according to the current recommendations from the CDC (Center of Disease Control). On the admission to the facility: for residents age 65 or older: If the resident has had the previous pneumococcal vaccine, offer the PCV (Pneumococcal Polysaccharide Vaccine) first.	F 334		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F 371		6/7/17

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F 371	Continued From page 23 (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure essential kitchen equipment was maintained in a sanitary manner. This had the potential to affect 45 of 45 residents who were served food out of the kitchen. Findings include: On 5/1/17, at 12:04 p.m. during the initial kitchen tour with the prep cook, it was observed that the entire hood screens located above the steamer, two conventional ovens and two stoves were covered with thick, fluffy loose, gray matter. On 5/1/17, at 4:15 p.m. during a follow-up visit in the kitchen, the prep cook verified fish was being baked in the convection oven and an uncovered pot of vegetable beef barley soup was cooking on the stove top, directly below the hood screens with thick, fluffy, loose, gray matter. On 5/2/17, at 1:32 p.m. the refrigerator for thickened liquid and supplements had spillage of dry brown liquid and dried paper adhered to the shelf on the bottom of the fridge. The assistant dietary manager verified the unclean of the refrigerator. The assistant dietary manager indicated she or the prep cook were responsible for cleaning the refrigerator, and stated they usually cleaned it when they saw it was dirty.	F 371	1) The hood screens were cleaned on May 8, 16 & 21, 2017. The refrigerator was cleaned on May 5, 2017 2) All residents have the potential to be affected by this practice. 3) Dietary Staff were educated on cleaning hood screens and refrigerators were reviewed and updated. 4) Dietary Director (or designee) will conduct random audits. 2 audits weekly for 4 weeks, then 1 audit/week for 4 weeks, then 2 audits monthly for 2 months. Audit results will be brought to QA monthly for further recommendations. 5) Dietary Diredtor or designee will be responsible for ensuring completion.	

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F 371	Continued From page 24 On 5/1/17, at 12:04 p.m. the prep cook was interview and stated the hood screens had recently been cleaned, however did not know the date. The April 2017 Monthly cleaning Schedule AM & PM-Shift Cook was reviewed with the prep cook and indicated the hood screen had not been signed off as cleaned for the month of April. The prep cook further stated, "Maybe December or January was the last time the screens had been professionally cleaned." On 5/2/17, at 1:10 p.m. during a follow-up visit of the refrigerator, the large spill of brown liquid and dried on piece of paper still remained. On 5/3/17, at 12:53 p.m. during review of the Monthly Cleaning Schedule and AM & PM- Shift Cook and CC & S AIDES sheets it was revealed that the last time the hood screens were cleaned was January 2017. Document from the maintenance director indicated a Work Order from Summit Companies for CAFE Hood Cleaning was last completed on 8/22/16. On 5/3/17, at 1:05 p.m. the dietary director (DD)-A stated the assistant dietary director was responsible to make sure the cleaning schedules were followed and completed. DD-A also stated they had not identified who was responsible to clean the refrigerator. DD-A further stated staff were supposed to put up a reminder to clean promptly after spills. The facility policy Cleaning Hoods and Filters dated 7/29/16, directed stove hoods and filters would be cleaned according to the cleaning schedule, or at least monthly.	F 371		
F 441	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL,	F 441		6/7/17

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F 441 SS=D	Continued From page 25 PREVENT SPREAD, LINENS	F 441		

(a) Infection prevention and control program.

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation,

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F 441	Continued From page 26 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide proper hand hygiene and glove usage for 1 of 3 residents (R28) reviewed for personal cares. Findings include: R28's Face Sheet printed 5/4/17, indicated diagnoses that included weakness, pain and anemia. R28's quarterly Minimum Data Set (MDS) dated 4/12/17, indicated R28 required	F 441	1) The staff involved with cares on R28 was educated on infection control and proper hand hygiene. 2) All residents have the potential to be affected by this. 3) All staff will be educated on the importance of infection control and proper hand hygiene. Annual in-service for Infection Control is being completed on 5/24/17 and on 5/31/17. Hand hygiene competencies will be completed on all	

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F 441	Continued From page 27 extensive assistance with personal hygiene. On 5/02/17, at 10:12 a.m. registered nurse (RN)-A and trained medication aid (TMA)-A were observed to enter R28's room. Both staff washed their hands and applied gloves. TMA-A half-filled a green wash basin with water and set it on a table, at the foot of the bed. RN-A assisted R28 to wash her face. RN-A covered R28's left side with a towel and proceeded to clean R28's right side. TMA-A covered R28's right side and cleaned R28's left side. RN-A removed her soiled gloves, did not do hand hygiene, and applied deodorant to R28. RN-A cued R28 she was going to clean and change her incontinent pad. RN-A donned clean gloves. RN-A wet a few paper towels and laid them on R28's bed. RN-A used the wet paper towel to wipe the excess bowel movement (BM) from R8's front peri-area. RN-A removed the feces soiled gloves and donned a clean pair of gloves without performing hand hygiene. RN-A wrung a washcloth in the basin, and wiped R28's front perineal area. RN-A continued to fold the washcloth as she continued to cleanse the BM. The wash cloth appeared heavily soiled with BM. RN-A returned the washcloth to the basin and washed the BM off of the cloth into the basin. RN-A resumed cleaning R28 with the same washcloth which was completely stained brown. RN-A again rinsed the washcloth off in the same dirty brown water, and once again used it to clean R28's perineal area, even though the washcloth was heavily soiled. Both staff then cued R28 to turn to the left side. TMA-A wrung the same heavily stained washcloth, using the soiled water, and provided pericare to R8. TMA-A went over to the basin and was rubbing and rinsing the heavily soiled and stained washcloth to get rid of visible	F 441	staff. 4) Care audits, including hand hygiene, will be completed on 2 random residents 2x/week for 1 month, then 2 random residents weekly for 2 months. Audit results will be brought to QA monthly for further recommendations. 5) DON or designee will be responsible	

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 _____	05/04/2017

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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BM. TMA-A squeezed the excess water off the washcloth and stated, "It's too dirty." TMA-A removed her soiled gloves, and applied a clean pair without performing hand hygiene. TMA-A then wet paper towels and continued to clean R28's bottom. At 10:31 a.m. the director of nursing (DON) came to R28's room and both RN-A and TMA-A requested more washcloths. At 10:32 a.m. RN-A removed her soiled gloves and left the room without performing hand hygiene. At 10:33 a.m. RN-A returned to the room, donned clean gloves, took the basin with soiled water and washcloth, squeezed the washcloth of excess water, dumped the soiled water into toilet, and placed the soiled washcloth in a clear plastic bag. RN-A rinsed the basin as she disposed of the water in the toilet. RN-A removed her gloves, did not perform hand hygiene, and ran fresh water to basin. RN-A added soap, and placed two washcloths in the water. Without performing hand hygiene, RN-A applied clean gloves, wrung out a washcloth, applied pericare cleanser to the cloth, cleansed R28's bottom, returned the washcloth to the water, and rinsed it. RN-A cleaned R28's bottom again, and then dropped the washcloth in the clear bag containing the soiled incontinent pad. Next, RN-A folded the visibly soiled piece of linen under R28. With the same gloved hands, RN-A grabbed a clean linen, tucked it under the soiled linen, and removed her soiled gloves. RN-A did not perform hand hygiene. RN-A reached out for a clean incontinent pad, and tucked it underneath R28. At 10:38 a.m. nursing assistant (NA)-A came to room, and applied gloves without performing hand hygiene. RN-A switched spots with NA-A, and RN-A was observed to wash her hands and left the room. At 10: 41 a.m. NA-A and TMA-A assisted R28 to get dressed. NA-A grabbed a tube of cleanser and

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F 441	Continued From page 29	F 441		

the clear untied plastic bag which contained both the soiled incontinent pad, wash cloth, and a towel that had been used to pat dry R28's bottom and set them directly on the floor as both staff adjusted R28's clothing and clean incontinent pad.

On 5/2/17, at 11:16 a.m. RN-A stated the facility policy for hand washing was to wash hands in between glove changes. RN-A also stated she should have changed gloves and washed her hands after pericare which involved BM. RN-A confirmed she should have not used the visibly soiled washcloth over and over to provide pericare nor should she have continued to rinse the washcloth in soiled water.

On 5/2/17, at 1:17 p.m. NA-A confirmed she should not have placed resident supplies directly on the floor.

On 5/4/17, at 2:08 p.m. DON stated staff were supposed to wash hands between gloving and were to use gloves properly. The DON stated staff were not supposed to set anything on the floor,

The facility Hand Hygiene policy dated 3/1/17, directed hands should be washed before and after direct contact with a client, if moving from a contaminated body site to a clean body site during care, and after removing gloves.

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	245554	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/02/2017**

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 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, State Fire Marshal Division, on 05/02/2017. At the time of this survey, Building 01 of Renvilla Health Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 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: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/25/2017

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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	245554	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/02/2017**

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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@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.

Building 01 of Renvilla Health Center was built in 1963, with building additions constructed in 1970 and 1993. This one-story with partial basement facility is fully fire sprinkler protected. The original building and both additions were determined to be of Type II(111) construction. In 2008, a resident wing addition was built. It is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type III(221) construction. Surveyed as one building.

The facility 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. The facility has a licensed capacity of 56 beds and had a census of 45 at time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:

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K 753	Continued From page 2	K 753		
K 753 SS=F	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: * Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. * Decorations meet NFPA 701. * Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. * Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6 or 19.7.5.6. * The decorations in existing occupancies are in such limited quantities that a hazard of fire is not present. 18.7.5.6, 19.7.5.6 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to restrict combustible decorations as required by the Life Safety Code (NFPA 101) 2012 edition section 19.7.5.6. This deficient practice could provide easy ignition of a fire and spread smoke and flame throughout the smoke compartment. This could affect 30 of the 56 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:30 am to 01:30 pm on 05/02/2017 observations revealed: 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	K 753	FSES will be successfully passed by 6/26/17	6/26/17

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K 753	Continued From page 3 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, 2012 edition. This deficient practice was confirmed by the Facility Maintenance Director (BR) at the time of discovery.	K 753		