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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 850C

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00343

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245228**
2.STATE VENDOR OR MEDICAID NO.
(L2) **019545601**

3. NAME AND ADDRESS OF FACILITY
(L3) **AVERA MORNINGSIDE HEIGHTS CARE CENTER**
(L4) **300 SOUTH BRUCE STREET**
(L5) **MARSHALL, MN** (L6) **56258**

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) **11/02/2009**

6. DATE OF SURVEY **03/26/2014** (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 **76** (L18)

13.Total Certified Beds **76** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(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):
Post certification revisit (PCR) of Health and Life Safety Code Surveys completed on March 26, 2014. Refer to CMS form 2567B.

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 04/01/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/05/2014 (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
08/01/1979
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/07/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245228

May 5, 2014 Sent through ePoc

Ms. Mary Maertens, Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, Minnesota 56258

Dear Ms. Maertens:

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 the above facility is certified for:

76 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 76 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program, Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 1, 2014

Ms. Mary Maertens, Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, Minnesota 56258

RE: Project Number S5228024

Dear Ms. Maertens:

On February 18, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 30, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On March 26, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 18, 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 January 30, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 11, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 30, 2014, effective March 11, 2014 and therefore remedies outlined in our letter to you dated February 18, 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

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
245228	A. Building B. Wing	3/26/2014

Name of Facility	Street Address, City, State, Zip Code
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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 **F0176** Reg. # **483.10(n)** LSC	Correction Completed **03/11/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/11/2014**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **03/11/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/11/2014**	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

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/KFD	05/05/2014	03048	03/26/2014
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
1/30/2014				

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245228	A. Building B. Wing 02 - NEW BUILDING AND RENOVATED EXI	3/18/2014

Name of Facility	Street Address, City, State, Zip Code
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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 K0147	Correction Completed 03/11/2014	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/KFD	Date: 05/05/2014	Signature of Surveyor: 22373	Date: 03/18/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 1/31/2014		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: 850C

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00343

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245228**

2.STATE VENDOR OR MEDICAID NO.
(L2) **019545601**

3. NAME AND ADDRESS OF FACILITY
(L3) **AVERA MORNINGSIDE HEIGHTS CARE CENTER**
(L4) **300 SOUTH BRUCE STREET**
(L5) **MARSHALL, MN** (L6) **56258**

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) **11/02/2009**

6. DATE OF SURVEY **01/30/2014** (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 **76** (L18)

13.Total Certified Beds **76** (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
	76			
(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 :
Wendy Buckholz, HFE NEII 02/27/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/06/2014 (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
08/01/1979
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/7/2014 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-5228

At the time of the January 30, 2014 standard survey the facility was not in substantial compliance with Federal participation requirements. 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.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 18, 2014

Ms. Mary Maertens, Administrator
Avera Morningside Heights Care Center
300 South Bruce Street
Marshall, MN 56258

RE: Project Number S5228024

Dear Ms. Maertens:

On January 31, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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>Electronic 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;

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Supervisor
Mankato Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
kathryn.serie@state.mn.us

Telephone: (507) 537-7158
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 March 11, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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,

- Include electronic acknowledgement signature of provider and date.

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

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 April 30, 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 July 30, 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 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 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
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

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

Enclosure

cc: Licensing and Certification File 5228s14.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING _____ B. WING _____	01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

(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 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to conduct an assessment to determine whether a resident was capable to self-administer medications for 1 of 7 residents (R57) observed during medication administration observation. Findings include: R57's diagnoses included diabetes, depression, hypertension and chronic pain. The initial minimum data set (MDS) dated 10/21/13, identified R57 had intact cognition with no short or long term memory impairment.	F 176	Reviewed incident of self administration with staff person involved. Staff person states she knows that resident 57 not appropriate for self administration. When staff went to administer resident's meds, resident's husband was present and resident asked if she could take her meds later, staff member stated she was nervous and unsure what to do so she left the pills for the resident to take. Reviewed with staff some alterate approaches that she could use instead of leaving pills with resident to take. On-going compliance: 1. Reviewed self administration of	3/11/14

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

Electronically Signed | 02/25/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING _____ B. WING _____	01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA MORNINGSIDE HEIGHTS CARE CENTER	300 SOUTH BRUCE STREET MARSHALL, MN 56258

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F 176	Continued From page 1 During an observation on 1/29/14, at 9:15 a.m., R57 was seated in her wheel chair at a table in the dining area of the first floor unit 2. R57 ate breakfast while her spouse sat with her. Trained medication aid (TMA)-A placed medications on the table in a white paper medication cup and stirred a medication into R57's juice. R57 stated she would take the medication later. TMA-A then exited the room and left the medication cup filled with oral pills and the medication added to the juice on the table, without noting whether R57 consumed the medications. During an interview on 1/29/14, at 9:18 a.m. TMA-A confirmed that she left the medications for R57 to take independently and indicated was a usual practice with R57. During an interview on 1/30/14, at 1:00 p.m. registered nurse (RN)-A confirmed the usual practice for resident self-administration of medications after staff set up would be as follows: (1) completion of a resident assessment related to ability and safety and then (2) receive an order from the physician. RN-A confirmed that a physician order had not been received nor had an assessment for self- administration been conducted for R57. RN-A further stated R57 does not have a medication self-administration assessment because "she would not be safe to do this." During an interview on 1/30/14, at 2:06 p.m. the administrator confirmed assessments are to be completed if a resident indicated the desire to self medicate. If the assessment failed to indicate the resident had the ability to safely self-administer or it the assessment had not been completed, the expectation would have been to remain with the	F 176	medication requirements and facility policy with staff at all staff meeting on 2/20/14. 2. Reviewed list of current residents approved for self administration of medication with staff at all staff meeting on 2/20/14. 3. Staff will be observed compliance with self administration policy through random observations of medication pass- see attached monitoring tool. 4. Residents approved for self administration of medications will have EMR audit completed to assure compliance with policy- see attached tool	

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F 176	Continued From page 2 resident to assure the medications had been taken. The facility policy titled, In Room Medication Pass Utilizing OPUS Medication System, revision date 2/2012, identified staff were to document whether the medication was consumed or refused.	F 176		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to conduct an assessment related to proper wheelchair positioning for 1 of 1 resident (R69) reviewed for proper positioning. Findings include: R69 was observed on 1/29/14, at 11:53 a.m. to propel herself independently in the dayroom area on first floor, unit 1 in her wheelchair (w/c). The wheelchair frame was bright blue in color with the appearance of a transport wheelchair. The brakes were located on the lightweight tubular structures which were used as handles. R69 was observed to lean to the right with her right forearm resting on the seat of the w/c.	F 309	OT assessment for w/c positioning completed on resident 69 on 2/4/14. As a result of assessment, resident required a different w/c which was given to resident on 2/4/14 and some adaptive equipment ordered for residents w/c on 2/4/14. Resident is also receiving OT services for 10 visits to address w/c positioning and safety. On-going compliance: All staff meeting on 2/20/14, reviewed with staff the Therapy Communication Screen Tool and policy and procedure. All staff will be required to follow policy. Report on results of therapy screens will be made to LTC QAPI committee, monthly x3 and quarterly therafter- see attached	3/11/14

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F 309	Continued From page 3 R69 was observed seated in her w/c by the nurses station on first floor unit 1 on 1/30/14, at 7:16 a.m. R69 was slumped the right side of the wheelchair, with her right forearm resting on the seat cushion. It was noted that R69 remained in the same position on 1/30/14, at 7:50 a.m. but appeared asleep. It was again observed on 1/30/14, at 2:46 p.m. that R69 remained seated in her w/c near the nurses station on the first floor, unit 1 and leaned to the right side, with her right forearm resting on the seat cushion. During record review for R69, the quarterly assessment dated 12/31/13 indicated R69 required extensive assistance with one person physical assist with all areas of mobility/transfers and personal hygiene. The brief interview for mental status (BIMS) scored 9, indicating moderate cognitive impairment. When interviewed on 1/29/14, at 3:01 p.m. the director of nursing (DON) confirmed that R69's w/c was "a little big for her" and stated she had noticed that R69 wasn't sitting up straight in that w/c. The DON confirmed that a wheelchair assessment related to proper positioning and safety had not been completed for R69 and further indicated that was a good idea. The DON again confirmed R69 had poor w/c positioning and also confirmed the chair was in poor repair, with the evidence of duct tape on the arm of the chair. When interviewed on 1/30/14, at 11:18 a.m. occupational therapy assistant (OTA)-C indicated she was unsure whether an assessment related to the wheelchair utilized by R69 had been conducted. OTA-C confirmed the w/c utilized by	F 309	quality monitoring tool.	

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F 309	Continued From page 4 R69 had not been one the facility had obtained. OTA-C further stated that the brakes on the w/c were not accessible to the resident and that the chair appeared too large for R69. OTA-C made a referral for a w/c assessment to be conducted by the occupational therapist (OT) after discussion with the surveyor. When interviewed on 1/30/14, at 12:26 p.m. the administrator/RN stated she was unsure whether therapy had completed an assessment related to positioning and safety for R69's w/c. She indicated she was unsure whether w/c assessments were routinely conducted by therapy upon admission but confirmed that nursing staff do not conduct wheelchair assessments. The administrator/RN confirmed that R69 was prone to poor positioning in the current w/c and stated, "We request assessments all the time - not sure why one hasn't been done". The administrator/RN reviewed R69's record and confirmed that R69 had last attended physical therapy (PT) in 3/2012 and occupational therapy (OT) in 5/2011 and confirmed on 1/30/14, at 2:49 p.m. that a recent w/c assessment had not been completed for R69.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to ensure 1 of 1	F 311	Reviewed identified concerns regarding resident 10 with neighborhood staff on	3/11/14

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F 311	Continued From page 5 resident (R10) who required limited assistance with eating, had been provided with appropriate services to maintain abilities. Findings include: Staff did not consistently provide assistance during the evening and morning meal observations on 1/27 and 1/28/14 when R10 failed to consume the food items served. During evening meal observation on 1/27/14, at 5:59 p.m. R10 was observed seated alone at a table along the back wall of the first floor unit 1 dining room. R10 called out, "Help me, help me, help me". NA-A placed R10's meal and covered plastic cup with milk in front of R10 at 6:02 p.m. and continued to serve other residents in the area. R10 was observed to drink the milk independently but stated, "Won't somebody please help me?" NA-A approached R10 at 6:05 p.m. and prompted R10 to eat her sandwich then walked away. R10 took only two bites of the sandwich then stopped eating and again chanted, "Help me, help me, help me", staff continued to dish up food, serve and assist other residents in the area; staff did not attempt to assist R10 after she had only consumed two bites of sandwich, but ignored the repeated comments. At 6:10 p.m., R10 took a bite of her sandwich and then picked up the covered cup containing her milk and started tapping it on the table chanting, "Help me, help me, help me". Staff did not respond to her request until 6:15 p.m., when registered nurse (RN)-B approached R10 and encouraged her to eat more. RN-A was	F 311	1/31/14. Resident Dining policy developed and reviewed with all staff at all staff meetings on 2/20/14. See attached dining policy. In order to address the resident's dining experience a PIP team has been developed and will begin meeting 3/3/14. The team will meet to develop an action plan that will address the dining experience. Representation on the team includes nursing, dietary, social services, administration. Direct care staff will have representation from day and evening shifts. On-going compliance: Random sampling of resident dining experience will be done. Results reported to LTC QAPI committee monthly x3, quarterly thereafter. See attached monitoring tool.	

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F 311	Continued From page 6	F 311		

observed to re-arrange R10's sandwich on the plate and then walked away to deliver a room tray to another resident. There was no attempt to assist her and/or remain with her and prompt her during the meal.

At 6:19 p.m. RN-A delivered a dish of chocolate pudding and a pre-packaged covered container of ice cream to R10. Without any prompting, RN-A removed R10's plate; it was noted that only approximately 25% of the sandwich had been consumed. Staff did not offer and/or sit next to R10 to assist and/or consistently prompt her during this meal observation.

At 6:23 p.m., R10 rolled the milk cup with the covered lid off the table onto the floor. NA-F, who was seated at the adjacent table and assisting other residents, picked the cup up from the floor immediately and transported it to the neighborhood kitchen without any verbal interaction and/or assistance with R10. R10 stated, "Will somebody please help me? I'm so hungry". NA-A then verbally prompted R10 to eat her pudding, which R10 then consumed. After eating the pudding, R10 picked up the ice cream container with the attached lid and placed the container up to her mouth, attempting to bite the lid off. R10 stated , "I can't do it, I can't eat it". R10 put the container down and put her hands up to her face and sobbed stating, "I can't do it". NA-A approached R10 and the resident stated, "Take it away". NA-A then removed the ice cream without any verbal interaction and/or offer of assistance. R10 started to chant, "Help me help me help me" and "I'm so hungry. Please, I need a drink, a drink, a drink, a drink,".

At 6:33 p.m. NA-A approached R10 and reported

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F 311	Continued From page 7	F 311		

that staff was getting a drink for her.
R10 stated, "Thank you sweetie". NA-E was observed to bring R10 a beverage in a covered sippy cup with handles on either side. After asking staff what the beverage was, NA-E advised R10 the beverage was strawberry Ensure. R10 stated, "That's so good" and drank the Ensure supplement without assistance. R10 continued to bang the cup on the table but when asked if she had finished, she stated, "No". R10 was assisted from the dining room at 6:38 p.m. as she stated, "I'm so hungry".

During breakfast observation on 1/28/13, at 9:00 a.m., R10 was observed seated alone at a table in the first floor unit one dining room. R10 had a divided plate with 2 half slices of toast with jelly and a plastic covered cup filled with milk in front of her; she was not observed to be eating.

At 9:04 a.m., NA-C prompted R10 to eat and R10 picked up her toast and ate a bite of her toast. She remained seated in the dining room with 1/2 slice of toast in her hand until 9:28 a.m. No staff was noted to approach, assist and/or prompt R10 to continue to eat. R10 closed her eyes and rested her head on her right hand, partially covering her face. At 9:30 a.m. R10 opened her eyes and looked around. and at 9:31 a.m. (26 minutes after prompted to eat her toast) NA-C approached R10 and asked her if she finished. R10 responded, "You can take it". NA-C removed the plate with the toast without any further prompting. NA-C left the container of milk and moved it within reach of her. R10 had consumed only approximately 50% of her toast. No further staff assistance was provided.

During observation and interview on 1/29/14, at

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F 311	Continued From page 8 1:20 p.m. CNA-B was observed seated next to R10 in the dining room and assisted her with the noon meal. CNA-B stated that staff were to assist R10 with meals as needed. CNA-B reported that R10 does well with finger foods but many times will not utilize the eating utensils and will require staff assistance and prompting. R10 was eating the meal without the behaviors noted the previous meals and consumed the meal. R10 was admitted with diagnoses including: senile dementia and loss of weight. Review of the minimum data set (MDS) dated 1/8/14 revealed that R10 required limited assistance with one person physical assist with eating. The plan of care dated 8/18/13 included: "I require limited assist of 1 staff to setup my food, tell me where foods are on my plate and give me cues with some direct feeding assist." When interviewed on 1/28/13, at 9:35 a.m. CNA-C stated that R10 does feed herself and requires supervision only. During interview on 1/30/14, at 12:56 p.m. the administrator/RN confirmed that R10 should have been assisted by staff during the times R10 called out for help during the evening meal on 1/27/14.	F 311		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program	F 441		3/11/14

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F 441	Continued From page 9 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility staff failed to ensure equipment was properly cleaned to prevent cross contamination between resident cares for 2 of 2 residents (R7 & R62) who were observed during glucometer checks.	F 441	Reviewed identified concerns with nurse involved in incidents and with all staff at all staff meetings on 2/20/14. Reviewed infection prevention policies: LTC IC Policy and Procedures and Computer Cleaning Procedures with staff at all staff meetings on 2/20/14.	

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F 441	Continued From page 10 Findings include: During an observation on 1/27/14, at 5:29 p.m. licensed practical nurse (LPN)-A with gloved hands checked R7's blood sugar with a multi-use glucometer. After the blood sugar check was completed and without the removal of the soiled gloves, LPN-A reached into her right uniform shirt pocket and retrieved a pen, wrote the glucometer reading on a piece of paper, placed the pen on the mobile computer table top, and manipulated the computer mouse to make an entry. This process was noted while she wore the same donned gloves worn while the blood sugar was checked. LPN-A then cleaned the glucometer appropriately, removed the soiled gloves, washed her hands and continued on to administer an insulin injection to R62. LPN-A did not sanitize/cleanse the computer mouse between the cares provided for R7 and R62, to prevent cross contamination. After the insulin had been administered, LPN-A manipulated the mouse (contaminated), obtained the computerized medication administration record for R62, opened the medication storage cabinet in R62's room and retrieved an insulin pen. After this process, LPN-A applied clean gloves and administered 18 units of Novolog insulin subcutaneously to R62. It was noted that LPN-A manipulated the computer mouse after the administration of the insulin and prior to the removal of the soiled gloves. LPN-A finally removed the soiled gloves and washed her hands. Again, the computer mouse was not disinfected, even though it had been manipulated with soiled gloves after the glucometer check and after the administration of medication. During an interview on 1/27/14, at 5:40 p.m. LPN-A confirmed she had touched the computer	F 441	On-going compliance: 1. Sanitizing products will be kept on all computers on wheels for staff use. 2. Random direct observation of staff will be done to assure compliance with Infection Prevention policies. See attached monitoring tool. 3. Results of monitoring activity will be reported to LTC QAPI monthly x3, quarterly therafter.	

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mouse with the same gloves worn when R7's blood sugar was checked and had not sanitized the computer mouse and then touched the mouse when the insulin injection for R62 was prepared. LPN-A stated "I don't bring wipes with me", the computers are not sanitized between residents they are only sanitized every evening.

During an interview on 1/30/14, at 1:00 p.m. registered nurse (RN)A confirmed the computer should have been sanitized between residents. RN-A further stated that if staff had touched the computer during resident care, the computer should not be taken into another resident's room without being sanitized.

During an interview on 1/30/14, at 2:07 p.m. the administrator/RN confirmed computers and accessories are expected to be sanitized between residents.

During an interview on 1/30/14, at 2:06 p.m. the administrator/RN confirmed staff was expected to sanitize the computers between residents if contaminated; for example, touching the mouse with gloves used for resident care.

The facility policy titled LTC IC Policy & Procedures identified the purpose to be protection of residents by preventing cross-contamination of infectious organisms. The policy heading titled IV. Cleaning Disinfection and Sterilization of Equipment #5 indicated: All equipment will be thoroughly cleaned between use of each resident.

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	245228	A. BUILDING **02 - NEW BUILDING AND RENOVATED EXISTING BLD** B. WING _____	**01/31/2014**

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AVERA MORNINGSIDE HEIGHTS CARE CENTER	**300 SOUTH BRUCE STREET** **MARSHALL, MN 56258**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on January 31, 2014. At the time of this survey, Avera Marshall Regional Medical Center Nursing 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 18 New 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/25/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING **02 - NEW BUILDING AND RENOVATED EXISTING BLD** B. WING _____	**01/31/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 Facsimile: 651-215-0525, or 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. Avera Marshall Regional Medical Center Nursing Home was constructed as follows: The original building was constructed in 1963, it is two-stories in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2004 Addition is two-stories in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The nursing home is separated from an attached hospital by 2-hour fire rated wall assemblies. The building has a fire alarm system with smoke detection in the corridors, which is monitored for automatic fire department notification. Additionally, all Resident Rooms are equipped with automatic smoke detection. The facility has a capacity of 76 beds and had a census of 76 at time of the survey. Due to the extensive renovation of the original	K 000		

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K 000	Continued From page 2 1963 building, the entire facility was surveyed as one building at NFPA 101 (2000) Chapter 18 New Health Care Occupancies. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based upon observation, the facility failed to maintain electrical wiring or equipment in accordance with NFPA 101 (2000 edition) Chapter 9, Section 9.1.2 and NFPA 70, National Electrical Code (1999 edition). This deficient practice could adversely affect 76 of 76 residents, staff and visitors. FINDINGS INCLUDE: On 01/31/2014 at 12:05 PM, above the lay-in ceiling, on the east-side of the double cross-corridor doors located in the Transitional Care Unit on the Ground Floor, observation revealed an open electrical junction box [missing cover plate]. This finding was confirmed with the maintenance manager at the time of discovery.	K 147	Missing cover plate installed on electrical junction box on 2/1/14. On-going compliance: facility does annual barrier management inspections. Electical junction boxes will be added to inspection form and be a part of the annual inspection.	3/11/14