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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 88J1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00566

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245241**
2.STATE VENDOR OR MEDICAID NO.
(L2) **764840500**

3. NAME AND ADDRESS OF FACILITY
(L3) **NORTHFIELD HOSPITAL LONG TERM CARE CENTER**
(L4) **2000 NORTH AVENUE**
(L5) **NORTHFIELD, MN** (L6) **55057**

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 **08/01/2016** (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)
12/31

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

12.Total Facility Beds **40** (L18)
13.Total Certified Beds **40** (L17)

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

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
	40			
(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 :
Gayle Lantto, Unit Supervisor 08/16/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/19/2016 (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
06/29/1981
(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
07/22/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245241

September 19, 2016

Ms. Tammy Hayes, Administrator
Northfield Hospital Long Term Care Center
2000 North Avenue
Northfield, Minnesota 55057

Dear Ms. Hayes:

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 August 12, 2016 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 16, 2016

Ms. Tammy Hayes, Administrator
Northfield Hospital Long Term Care Center
2000 North Avenue
Northfield, MN 55057

RE: Project Number S5241028

Dear Ms. Hayes:

On June 24, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 9, 2016 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 August 1, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 12, 2016 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 June 9, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 12, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 9, 2016, effective August 12, 2016 and therefore remedies outlined in our letter to you dated June 24, 2016, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245241 Y1	A. Building B. Wing Y2	8/1/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHFIELD HOSPITAL LONG TERM CARE CENTER	2000 NORTH AVENUE NORTHFIELD, MN 55057

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 06/24/2016	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 (INITIALS) GD/kfd	DATE 8/15/2016	SIGNATURE OF SURVEYOR 33043	DATE 8/1/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/9/2016	☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245241 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/12/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHFIELD HOSPITAL LONG TERM CARE CENTER	2000 NORTH AVENUE NORTHFIELD, MN 55057

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0038	08/12/2016	LSC K0048	07/15/2016	LSC K0050	07/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0067	08/01/2016	LSC K0076	07/01/2016	LSC K0154	07/15/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0155	07/15/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	8/15/2016	37008	8/12/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/9/2016

☐ 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: 88J1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00566

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245241**

2. STATE VENDOR OR MEDICAID NO.
(L2) **764840500**

3. NAME AND ADDRESS OF FACILITY
(L3) **NORTHFIELD HOSPITAL LONG TERM CARE CENTER**
(L4) **2000 NORTH AVENUE**
(L5) **NORTHFIELD, MN** (L6) **55057**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/09/2016** (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)
12/31

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

12. Total Facility Beds **40** (L18)

13. Total Certified Beds **40** (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
	40			
(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 :
Mary Bruess, HFE NEII — 07/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 07/22/2016 (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
06/29/1981
(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**	INVOLUNTARY
01-Merger, Closure		05-Fail to Meet Health/Safety
02-Dissatisfaction W/ Reimbursement		06-Fail to Meet Agreement
03-Risk of Involuntary Termination		OTHER
04-Other Reason for Withdrawal		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
June 24, 2016

Ms. Tammy Hayes, Administrator
Northfield Hospital Long Term Care Center
2000 North Avenue
Northfield, Minnesota 55057

RE: Project Number S5241028

Dear Ms. Hayes:

On June 9, 2016, 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:

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gayle.lantto@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

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 July 19, 2016, 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 July 19, 2016 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 September 9, 2016 (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 December 9, 2016 (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

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
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245241	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHFIELD HOSPITAL LONG TERM CARE CENTER	2000 NORTH AVENUE NORTHFIELD, MN 55057

(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 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		7/8/16

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

Electronically Signed | 07/01/2016

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
	245241	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHFIELD HOSPITAL LONG TERM CARE CENTER	2000 NORTH AVENUE NORTHFIELD, MN 55057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 1 (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 failed to ensure a glucometer was properly disinfected. This had the potential to affect 9 residents residing in the facility who utilized the shared glucometer. In addition, the facility failed to ensure Tuberculosis (TB) screening was completed and properly documented for 5 of 5 residents (R12, R31, R55, R85, R90) reviewed. Findings include: Glucometer Sanitizing R19's blood sugar testing was observed on 6/8/16, at 11:41 a.m. completed by a licensed practical nurse (LPN)-A. LPN-A washed her hands, donned gloves, and then completed the testing. LPN-A reported the results showed R19 required insulin (based on a sliding scale determined by test results). The nurse left R19's room and placed the glucometer on top of the	F 441	Glucometer Sanitizing: Glucometer Sanitizing Instructions have been clarified. The cleaning product has been changed to Clorox Healthcare Bleach Germicidal Wipes with a contact time of 1 minute for Bacteria, Viruses, Bloodborne Pathogens. This product is a 1:10 bleach dilution. "Meets CDC and APIC guidelines for surface disinfection of the toughest healthcare pathogens"." On the product information it states these wipes are specially formulated with an anticorrosion agent and are compatible on the following medical products, (a long list which includes Blood Glucose Monitors). The Precision Xceed Pro Blood Glucose Monitoring device Cleaning Instructions are “Clean the monitor by wiping it with a damp cloth or sponge moistened with a mild detergent.”	

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F 441	Continued From page 2 medication cart. After administering insulin to R19 LPN-A returned to the medication cart, obtained a wipe from a canister (purple lid) and wiped the glucometer for approximately 3-5 seconds. LPN-A disposed of the wipe, and then obtained a second wipe and re-wiped the glucometer for approximately three more seconds before placing the machine back into a plastic case. LPN-A reported she had used the second wipe "just to make sure the glucometer was clean." The nurse then confirmed the glucometer was used for additional residents. LPN-A said she had been instructed to wipe the glucometer with a Sani Wipe and then place the machine back into the case to dry. LPN-A stated there was no designated length of time the glucometer needed to be wiped or remain wet, and re-stated, "I just wipe it off." The following day at 12:35 p.m. LPN-B stated the glucometer was utilized by more than one resident for blood sugar checks. LPN-B stated she cleaned the glucometer after each use and used a purple wipe to rub all around the glucometer for 2-3 seconds. LPN-B stated she had not been instructed by anyone at the facility as to how glucometers should have been disinfected, and that was just the way she did it. On 6/9/16, at 1:01 p.m. the assistant director of nursing (ADON) stated she knew the nurses had been trained on how to disinfect glucometers, but was unsure of the procedure. The ADON stated she did see the nurses using the purple wipes to clean glucometers. At 1:10 p.m. the DON stated she knew the nurses used Sani Wipes to clean the glucometers, but knew of no length of time required in order to	F 441	All nursing staff will be trained in the glucometer sanitizing process and following the written instructions. The DON will perform quarterly audits by observation and report at the quarterly Quality Committee Meetings through 4/2017. TB Screening: LTCC TB Prevention Plan has been updated to include Baseline TB Screening for all residents upon admission. Administration of two-step Mantoux instructions have been clarified, and the documentation of mm induration had been made a mandatory field in our online documentation. Nursing staff will be trained on our Plan and Instructions. All current residents will be screened using the Tool per "Regulations for TB Control in Minnesota Health Care Settings" 2013. The documented screening tool and a 1-Step Mantoux (per Beth Kingdon) will be administered to all current residents. The DON will perform audits and report at quarterly Quality Committee Meetings through 4/17	

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F 441	Continued From page 3	F 441		

properly ensure the device was disinfected. The DON then verified on back of the Sani Wipe canister it indicated surfaces needed to stay wet for two minutes and then allowed to dry for proper disinfection. DON stated the nurses had just been wiping the glucometers after use and not keeping the glucometer wet for two minutes as recommended on the Sani wipe canister.

A related policy was requested, but was not provided.

TB screenings
Review of R12, R31, R55, R85 and R90's medication administration records (MARs) indicated the first and second tuberculin skin testing (TST) was administered six and seven days apart. The 2013 TB Guidelines recommended testing should have been administered at least nine days apart. The MARs also did not indicate the induration in millimeters as required. In addition, R12, R31, R55, R85 and R90's records lacked evidence of symptom screenings and TB history, and facility staff were not able to provide this information.

During an interview with the director of nursing (DON) on 6/9/16, at 10:49 a.m. she indicated resident screenings "just have never been done," only the 2-step testing. The DON stated the facility had incorporated the 2013 guidelines into their policy but had not implemented them. The DON said she was responsible, and knew how to ensure the necessary changes were made.

At 10:54 a.m. the infection control preventionist verified she was in charge of the facility's infection control program, however, did not have responsibility for the TB program.

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F 441	Continued From page 4 The facility's 2/14, Resident Tuberculosis Prevention policy indicated "...to reduce the risk of cross transmission of tuberculosis...TST documentation for all residents should include the date, the number of millimeters of induration [if no induration, document "0" mm]." The policy did not indicate the time length between step one and step two testing. The policy also did not indicate that step one and step two of the three step baseline TB screening process be completed for the residents.	F 441		

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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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 6/9/2016, Northfield Hospital & Long Term Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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		07/01/2016

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

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K 000	Continued From page 1 By 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. Northfield Hospital & Long Term Care Center is a 2-story building and is located on 1st floor. The facility was built in 2002 and was determined to be of Type 1(332) construction, with no basement. The facility is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 37 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section	K 038		8/12/16

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K 038	Continued From page 2 7.1. 19.2.1 This STANDARD is not met as evidenced by: 2000 NFPA 101 LIFE SAFETY CODE STANDARD Based on observation, the facility has failed to provide proper exit hardware on exit doors to the stairwell exit access doors. This deficient practice could affect the safe and rapid evacuation of all residents, visitors and staff in the event of an emergency that may require quick evacuation. Findings include: On facility tour between 09:00 AM and 02:00 PM on 06/09/2016, it was observed that the exit doors from the corridor to the stairwells are locked with magnetic locking devices and the exit access doors from the stairwells to the public way are locked with magnetic locking devices in the following areas: 1.Sign age on doors need to be ledge able per LSC section 7.2.1.6.1 (d) 2. Delay egress locks do not unlock after the 3 second timers starts with-in the15 seconds. 3.Stairwells need sign age not a Exit. This deficiency was verified by Director of Facility Services	K 038	Ledgeable Signage: Two new signs have been placed on hallway exit doors in Clear Large Font reading "PUSH UNTIL ALARM SOUNDS - DOOR CAN BE OPENED IN 15 SECONDS" Completed 6/14/16 Delay Egress Locks: Parts have been ordered and expected completion is 8/12/16 Stairwell Signage: The 2 Stairwells have new signage up Stating "NOT AN EXIT" Completed 6/14/16 Director of Facility Services is responsible for corrections.	
K 048 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1	K 048	Written Plan For Evacuation: Policy has been modified to state residents are moved through Smoke	7/15/16

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K 048	Continued From page 3 On facility tour between 09:00 AM and 2:00 PM on 06/09/2016, observation and documentation show moving residents through double doors and not through smoke barriers doors.	K 048	Barrier Doors. Signage has been placed identifying the doors as Smoke Barrier Doors and Staff will be educated. Director of Facility Services and Safety Director are responsible for these corrections.	
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 On facility tour between 09:00 AM and 2:00 PM on 06/09/201^, observation and documentation reviewed revealed that Fire drills for 2nd shaft 2 and 3rd quarters need to be space out more than 90 minutes apart. Your documentation did not show that transmission report.	K 050	Fire Drills: Fire drills will be scheduled to follow this standard as described. Completed. Safety Officer is responsible for this correction. Safety Officer will conduct audits and report at quarterly Quality Committee Meetings through 4/2017.	7/1/16

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K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 On facility tour between 09:00 AM and 2:00 PM on 06/09/2016, observation shows the Gas fireplace in dining area has unprotected glass in front of fireplace with space to reach behind the glass.	K 067	Heating Ventilating: The gas fireplace glass will be replaced with a new glass 2 inches larger to more fully cover the fireplace. The new glass has been ordered and will be completed by 8/1/16 Facility Services Director is responsible for this correction.	8/1/16
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 This STANDARD is not met as evidenced by: Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than	K 076	Medical Gas Storage: The floor of the storage area has been taped to identify the area that must be kept clear. All items within 5 feet have been relocated. Signage has been placed to remind staff. All staff have been educated about clear storage area. Director of Facility Services and DON are	7/1/16

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K 076	Continued From page 5 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. On facility tour between 09:00 AM and 2:00 PM on 06/09/2016, observation shows the Medical gas is stored with other storage items. They need 5' feet separations.	K 076	responsible. DON will complete audits of area and report at quarterly Quality Committee Meetings through 4/17.	
K 154 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: K-154: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 09:00 AM and 2:00 PM on 06/09/2016, observation and documentation reviewed revealed your records do not show out of service for 4 hours within a 24 hour period for fire sprinkler. This deficient practice was confirmed by the Facility Maintenance Director at the time of	K 154	Sprinkler System: Policy wording will be modified to "Out of Service for 4 hours within a 24 hour period for fire sprinkler." Education will occur for Facilities and Safety Staff who implement the process. The Director of Facilities and the Safety Officer are responsible for this correction.	7/15/16

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K 154	Continued From page 6 discovery.	K 154		
K 155 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: K-155 Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 09:00 AM and 2:00 PM on 06/09/2016, observation and documentation reviewed revealed that your records do not show out of service for 4 hours within a 24 hour period for fire alarm. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 155	Fire Alarm System: Policy wording will be modified to "Out of Service for 4 hours within a 24 hour period for fire alarm system." Education will occur for Facilities and Safety Staff who implement the process. The Director of Facilities and the Safety Officer are responsible for this correction.	7/15/16

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 24, 2016

Ms. Tammy Hayes, Administrator
Northfield Hospital Long Term Care Center
2000 North Avenue
Northfield, Minnesota 55057

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5241025

Dear Ms. Hayes:

The above facility was surveyed on June 6, 2016 through June 9, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contac Gayle Lantto at (651) 201-3794 or email: gayle.lantto@state.mn.us.**

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

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

Please feel free to call me with any questions.

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
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00566	A. BUILDING: _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHFIELD HOSPITAL LONG TERM CARE C	2000 NORTH AVENUE NORTHFIELD, MN 55057

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the work "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 6, 2016 through June 9, 2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		7/8/16

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2 302	Continued From page 3 Based on interview and document review, the facility failed to ensure consumers were provided information regarding Alzheimer's disease or related disorders as required. Findings include: During a review of the facility's Alzheimer's training program, evidence was lacking to show consumers had been provided in written or electronic, a description of Alzheimer's training program, the categories of employees trained, the frequency of training and the basic topics covered as required. At the time of the survey the facility had residents with diagnoses of Alzheimer's disease or other dementia. When interviewed, 6/9/16 on at 10:03 a.m. the director of nursing (DON) stated written or electronic information provided to consumers was unavailable stating, "I looked on line and in the admission packet. We don't do it. I missed it. I see it in the regulations. I can fix it." She provided a copy of the Minnesota Statute 144.6503 for dementia training, and explained the staff utilized the statutes as a resource. On 6/9/16, at 12:30 p.m. the DON reported the facility did not have a policy related to required dementia training. SUGGESTED METHOD OF CORRECTION: The DON or designee could add information regarding staff training to the resident admission packet so consumers were aware of this information. The DON or designee could conduct audits to ensure compliance, and the audits could be reviewed by the quality committee.	2 302	Alzheimer's Disease: Information regarding staff Dementia Training has been added to the Admission Packets for all new residents. Notice to current families and residents will be given and posted on the Long Term Care Center.	

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2 302	Continued From page 4 TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 302		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a glucometer	21390	Glucometer Sanitizing: Glucometer Sanitizing Instructions have	7/8/16

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21390	Continued From page 5 was properly disinfected. This had the potential to affect 9 residents residing in the facility who utilized the shared glucometer. Findings include: R19's blood sugar testing was observed on 6/8/16, at 11:41 a.m. completed by a licensed practical nurse (LPN)-A. LPN-A washed her hands, donned gloves, and then completed the testing. LPN-A reported the results showed R19 required insulin (based on a sliding scale determined by test results). The nurse left R19's room and placed the glucometer on top of the medication cart. After administering insulin to R19 LPN-A returned to the medication cart, obtained a wipe from a canister (purple lid) and wiped the glucometer for approximately 3-5 seconds. LPN-A disposed of the wipe, and then obtained a second wipe and re-wiped the glucometer for approximately three more seconds before placing the machine back into a plastic case. LPN-A reported she had used the second wipe "just to make sure the glucometer was clean." The nurse then confirmed the glucometer was used for additional residents. LPN-A said she had been instructed to wipe the glucometer with a Sani Wipe and then place the machine back into the case to dry. LPN-A stated there was no designated length of time the glucometer needed to be wiped or remain wet, and re-stated, "I just wipe it off." The following day at 12:35 p.m. LPN-B stated the glucometer was utilized by more than one resident for blood sugar checks. LPN-B stated she cleaned the glucometer after each use and used a purple wipe to rub all around the glucometer for 2-3 seconds. LPN-B stated she had not been instructed by anyone at the facility	21390	been clarified. The cleaning product has been changed to Bleach Germicidal Wipes with a contact time of 1 minute. All nursing staff will be trained in the glucometer sanitizing process. The DON will perform quarterly audits by observation and report at the quarterly Quality Committee Meetings through 4/2017.	

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21390	Continued From page 6 as to how glucometers should have been disinfected, and that was just the way she did it. On 6/9/16, at 1:01 p.m. the assistant director of nursing (ADON) stated she knew the nurses had been trained on how to disinfect glucometers, but was unsure of the procedure. The ADON stated she did see the nurses using the purple wipes to clean glucometers. At 1:10 p.m. the DON stated she knew the nurses used Sani Wipes to clean the glucometers, but knew of no length of time required in order to properly ensure the device was disinfected. The DON then verified on back of the Sani Wipe canister it indicated surfaces needed to stay wet for two minutes and then allowed to dry for proper disinfection. DON stated the nurses had just been wiping the glucometers after use and not keeping the glucometer wet for two minutes as recommended on the Sani Wipe canister. A related policy was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The DON or infection control preventionist could ensure policies reflect current standards/recommendations for properly disinfecting glucometers, and staff performing the testing is trained. Audits could be conducted to ensure compliance, and the results brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control	21426		7/8/16

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21426	Continued From page 7 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure tuberculosis (TB) screening was completed and properly documented for 5 of 5 residents (R12, R31, R55, R85, R90) reviewed. Findings include: R12, R31, R55, R85 and R90's medication administration records (MARs) indicated the first and second tuberculin skin testing (TST) was administered six and seven days apart. The 2013 TB Guidelines recommended testing should have been administered at least nine days apart. The	21426	TB Screening: LTCC TB Prevention Plan has been updated to include Baseline TB Screening for all residents upon admission. Administration of two-step Mantoux instructions have been clarified, and the documentation of mm induration had been made a mandatory field in our online documentation. Nursing staff will be trained on our Plan and Instructions. All current residents will be screened using the Tool per "Regulations for TB Control in Minnesota Health Care Settings" 2013. The documented screening tool and a	

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21426	Continued From page 8 MARs also did not indicate the induration in millimeters as required. In addition, R12, R31, R55, R85 and R90's records lacked evidence of symptom screenings and TB history, and facility staff were not able to provide this information. During an interview with the director of nursing (DON) on 6/9/16, at 10:49 a.m. she indicated resident screenings "just have never been done," only the 2-step testing. The DON stated the facility had incorporated the 2013 guidelines into their policy but had not implemented them. The DON said she was responsible, and knew how to ensure the necessary changes were made. At 10:54 a.m. the infection control preventionist verified she was in charge of the facility's infection control program, however, did not have responsibility for the TB program. The facility's 2/14, Resident Tuberculosis Prevention policy indicated "...to reduce the risk of cross transmission of tuberculosis...TST documentation for all residents should include the date, the number of millimeters of induration [if no induration, document "0" mm]." The policy did not indicate the time length between step one and step two testing. The policy also did not indicate that step one and step two of the three step baseline TB screening process be completed for the residents. SUGGESTED METHOD OF CORRECTION: The DON or infection control preventionist could ensure the facility policies reflect current standards, and residents have been screened and tested utilizing current standards/requirements. An audit procedure could be implemented, and the results brought to the quality committee for review.	21426	1-Step Mantoux (per Beth Kingdon) will be administered to all current residents. The DON will perform audits and report at quarterly Quality Committee Meetings through 4/17	

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21426	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		