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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 8CCN
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 **05/24/2018** (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
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
	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):

17. SURVEYOR SIGNATURE
Lois Boerboom, HFE NE II
Date: 06/11/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL
Alison Helm, Enforcement Specialist
Date: 06/11/2018 (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 **05/09/2018** (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions) 020499

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

CMS Certification Number (CCN): 245228 June 11, 2018

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

Dear Ms. Derynck:

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 May 15, 2018 the above facility is certified for:

76 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered June 11, 2018

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

RE: Project Number S5228028

Dear Ms. Derynck:

On April 18, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 5, 2018 . 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 May 24, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 8, 2018 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 April 5, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 15, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 5, 2018, effective May 15, 2018 and therefore remedies outlined in our letter to you dated April 18, 2018, 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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8CCN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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(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 **04/05/2018** (L34)

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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
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___ 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

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(L37)	(L38)	(L39)	(L42)	(L43)

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

17. SURVEYOR SIGNATURE Date :
Thomas O'Brien, HFE - NE II 05/07/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 05/08/2018 (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
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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

Electronically delivered
April 18, 2018

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

RE: Project Number S5228028

Dear Ms. Derynck:

On April 5, 2018, 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 electronically delivered CMS-2567, whereby corrections are required. In addition, at the time of the April 5, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5228015 that was found to be unsubstantiated.

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;

<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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
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 May 15, 2018, 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 May 15, 2018 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 July 5, 2018 (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 October 5, 2018 (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.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245228	A. BUILDING ______ B. WING ______	C 04/05/2018

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
E 000	Initial Comments A survey for CMS Appendix Z Emergency Preparedness Requirements, was conducted on 4/2/18 through 4/5/18, during a recertification survey. The facility is NOT in compliance with Appendix Z, Emergency Preparedness Requirements.	E 000		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a communication plan, which included a method for sharing appropriate information from the emergency preparedness plan (EPP) with residents, families or representatives. This had the potential to affect 71 of 71 residents currently residing in the facility, as well as staff and visitors. Findings include: The facility's EPP dated 11/2017, was reviewed. The communication plan did not include information regarding the method of how the facility planned to share the EPP with residents,	E 035	-Emergency operations plan and hazards vulnerability assessment were reviewed by DON and Emergency Preparedness officer on 4/24/18. A letter of notice was created to provide education to families and residents on the emergency operations plan. (see attached) This notice along with the policy will be sent out via mail to all current families prior to 5/1/18. This notice was also added to admission packets and the admission checklist(see attached)on 4/26/18 to provide ongoing education to new admissions and their families. Emergency preparedness will also be the education	4/30/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/26/2018

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 ______ B. WING ______	C **04/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 035	Continued From page 1 families and representatives. On 4/4/18, at 1:15 p.m. the administrator stated information on how the facility planned to share the EPP was provided to residents, families and representatives via the admission packet. A review of the admission packet provided to the survey team revealed there was no information included regarding the facility's EPP. The administrator verified this, and stated EPP information for consumers was supposed to be in the admission packet but was not there.	E 035	topic at the upcoming family night on 5/30/18. The emergency preparedness plans and the hazards vulnerability assessment will be reviewed annually with the facility wide resource assessment at the quality committee meetings each October.	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at	E 037		5/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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
E 037	Continued From page 2 least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE	E 037		

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	245228	A. BUILDING ______ B. WING ______	C 04/05/2018

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E 037	Continued From page 3	E 037		

organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection,

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E 037	Continued From page 4 and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to train new and current staff regarding policies and procedures in the facility's emergency preparedness plan (EPP). This had the potential to affect 71 of 71 residents currently residing in the facility, as well as staff and visitors. Findings include: The facility's EPP dated 11/2017, was reviewed. There was no documented evidence staff were trained on the EPP communication or evacuation	E 037	Emergency policies were reviewed by DON and Emergency Preparedness Officer on 4/24/18. Education PowerPoint (see attached) was created and education will be done with all current staff regarding patient triage and emergency preparedness during staff meetings scheduled on 5/3/18 and 5/10/18. Ongoing education plan moving forward will be to assign the education via computer based learning upon hire and on an annual basis. During the interim of	

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E 037	Continued From page 5 plan policies and procedures. During an interview on 4/4/18, at 1:15 p.m. the administrator stated the facility staff had not been trained on the EPP policies and procedures regarding their communication or evacuation plans. The administrator further stated they planned on doing the training in the future, but the exact date and agenda had not been determined yet.	E 037	the computer based learning module to be available,a copy of EP policy and triage power point will be added to new hire orientation binders effective 4/26/18. Nursing Managers will receive automatic alerts for any computer based learning assignments that are not completed by due date and will follow up with staff who are overdue on their education. Any overdue employee CBL's will be brought to the quality meeting and reviewed monthly.	
F 000	INITIAL COMMENTS On 4/2/18 through 4/5/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. 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. At the time of the survey, an investigation of complaint H5228015 was completed and was found to be unsubstantiated.	F 000		

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		5/15/18

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F 880	Continued From page 7 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to minimize the risk for spread of infection related to the cleansing and disinfection the blood glucose meter (device used to test blood sugar levels) for 2 of 3 residents (R20, R45) observed to have blood glucose meter checks. Findings include: On 4/4/18, at 7:56 a.m. licensed practical nurse	F 880	Whole Blood Glucose Testing policy and the glucose testing competency was reviewed by the DON on 4/24/18. Both of these items specify that the glucometer should be cleaned and allowed a 3 minute dry time between patient use. All staff are currently required to complete the competency prior to being set up in the system. All nurses and TMA's will receive re-education and complete the competency on glucose testing and	

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F 880	Continued From page 8 (LPN)-A was observed to perform a blood glucose test for R20 in the resident's room. At 7:59 a.m., LPN-A cleansed the glucometer for approximately five seconds with a Sani-Cloth (PDI Sani-Cloth AF3 Germicidal Disposable Wipe). On 4/4/18 at 8:00 a.m., LPN-A brought the same glucometer into R45's room and performed a blood glucose test. At 8:08 a.m. after LPN-A left R45's room LPN-A wiped the blood glucose meter for approximately five seconds with a Sani-Cloth and set the glucometer on a table. At that time, LPN-A was interviewed and stated the blood glucose meters needed to wiped down with a Sani-Cloth after each resident use and should be allowed to dry for a "minute or two." On 4/4/18, at 1:24 p.m. the infection control nurse (ICN) stated the proper technique for cleansing a glucometer following use, was to wipe the machine using a Sani-Cloth wipe. The ICN further explained the surface of the blood glucose meter needed to remain wet for 3 minutes for the cleanser to be effective. The ICN reiterated it was an expectation that staff would ensure the blood glucose meter was disinfected for 3 minutes before using it on another resident. R20's physician orders printed on 4/5/18, indicated R20 had blood sugar checks completed four times daily. R45's physician orders printed on 4/5/18, indicated R45 had blood sugar checks completed twice daily. Directions for usage of the Sani-Cloth for infection control was reviewed and indicated to	F 880	cleaning protocols by 5/15/18. A checklist/competency will be created by 6/30/18 and will be assigned annually going forward, to all staff who are trained to use the glucometers. Ongoing monitoring of appropriate cleaning of the glucometers will be done by use of the attached tracking tool. Beginning 4/30/18 nursing managers will audit 10 glucose checks per month x3 months and then 10 audits every 3 months thereafter. Glucose monitor audit results will be added to quality scorecard and reviewed monthly at quality committee meetings	

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F 880	Continued From page 9 thoroughly wet a surface and allow treated surface to remain wet for three minutes. An undated competency form titled Stat Strip Glucose Monitoring System, indicated to clean the meter with a Clorox (bleach) wipe after each patient use, and to allow three minutes of wet time. On 4/5/18, at 10:45 a.m. registered nurse (RN)-A verified residents shared the glucometer. On 4/5/18, at 10:00 a.m. the administrative assistant stated the facility did not have a policy on cleaning glucometers.	F 880		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.	F 947		4/30/18

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F 947	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide dementia management training and resident abuse prevention training, for 1 of 5 nursing assistants (NA-A) whose personnel records were reviewed. Findings include: On 4/5/18, at 8:53 a.m. NA-A's transcripts from the facility's Learning Center Health Stream web-based training site dated 4/5/18, were reviewed. The transcript indicated NA-A's last completed dementia management and resident abuse prevention training had been completed on 1/6/17. On 4/5/18, at 9:05 a.m. education coordinator (EC)-A reviewed NA-A's training transcript in the facility's Learning Center Health Stream web based training system. EC-A verified the transcript indicated NA-A had not completed the dementia management training, or the resident abuse prevention training, that had been assigned to be completed. EC-A explained when the in-services were assigned to the employees the employee would receive an e-mail notification message daily, until the training had been completed. In addition, EC-A stated the employee's supervisor also received e-mail notifications weekly. EC-A verified NA-A had been due to complete the dementia management and resident abuse prevention training in January 2018. The facility's policy for mandatory training was requested, but none was provided.	F 947	Alzheimer□s Disease/Staff Training policy and the education development policy reviewed by the DON on 4/24/18. All staff currently receive mandatory education including Alzheimer's and vulnerable adult training via computer based learning (CBL)assignments. Staff receive email alerts when CBL□s are assigned and daily alerts when they become overdue. DON and nurse managers will pull a list of all staff with overdue education CBLs. Staff identified with overdue mandatory education CBLs will have them completed no later than 4/30/18 or before their next scheduled shift. Staff who do not complete their overdue assignments will be subject to disciplinary action. Going forward, nurse managers will receive automatic alerts for staff who have overdue CBL□s and follow up with employees to get them completed prior to next scheduled shift. Overdue CBL reports will be brought monthly to the quality committee meeting for review	

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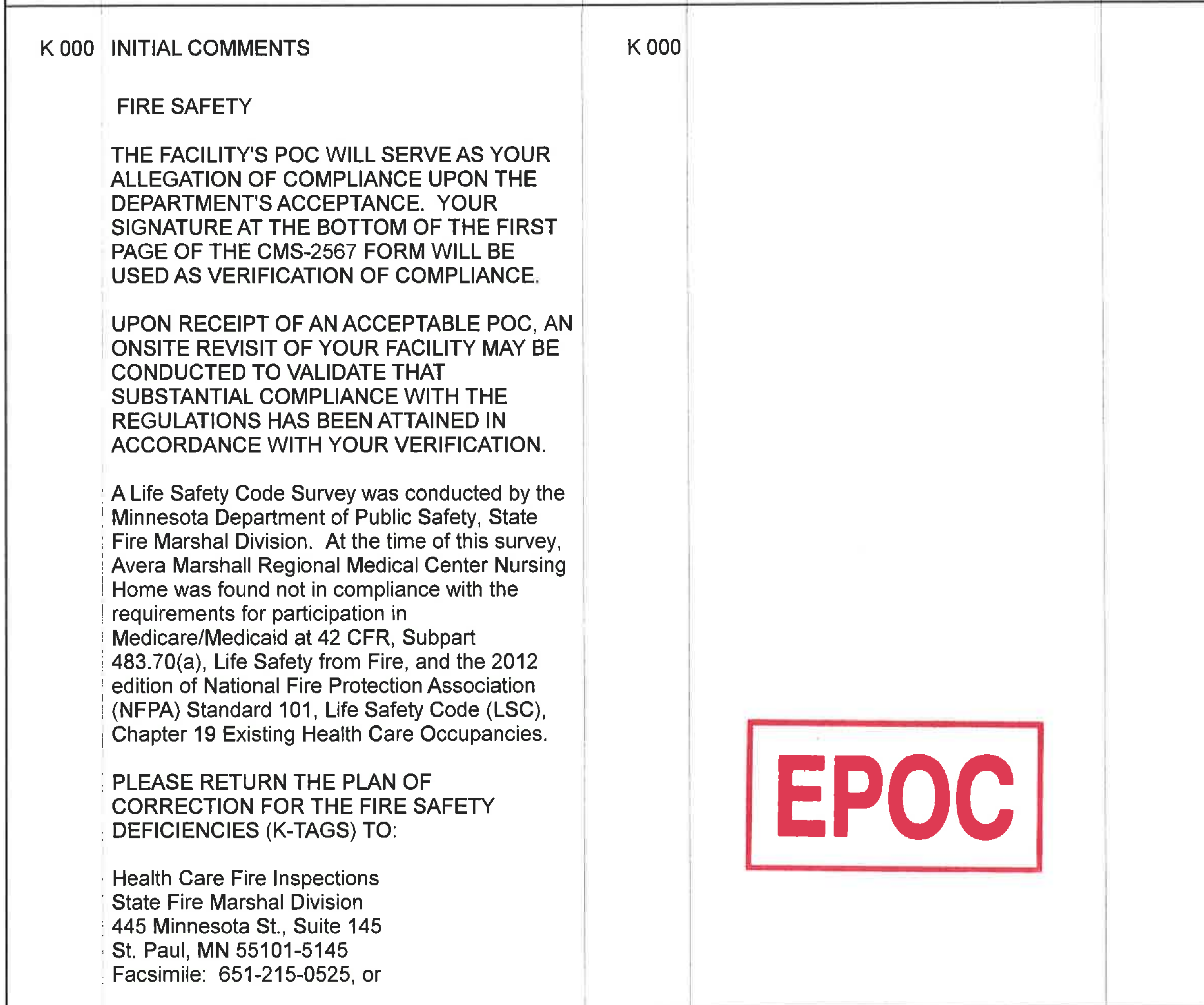

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Avera Marshall Regional Medical Center Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145 Facsimile: 651-215-0525, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/26/2018

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

"If participating in the E-POC process, a paper copy of the plan of correction is not required."

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.

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K 000	Continued From page 2 Additionally, all Resident Rooms are equipped with automatic smoke detection. The facility has a capacity of 76 beds and had a census of 74 at time of the survey. Due to the extensive renovation of the original 1963 building, the entire facility was surveyed as one building at NFPA 101 (2012) Chapter 19 Existing Health Care Occupancies. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________ b) Who provided system test _____________ c) Water system supply source _____________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain the automatic sprinkler system	K 353	Sprinkler inspection was completed on 4/10/2018. Ongoing inspections have	4/26/18

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

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K 353	Continued From page 3 in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice could affect 74 out of 74 residents. Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked ______ b) Who provided system test ______ c) Water system supply source ______ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 4/05/18, during documentation review, it was revealed that the Annual Fire Sprinkler Inspection was conducted outside of the required time frame. The last documented inspection that was available for review occurred on 03/28/2017. This deficient practice was verified by the Facility Maintenance Director.	K 353	been added as a recurring reminder to the maintenance team's outlook calendars and the sprinkler company has the future schedule set up for annual checks at Morningside Heights to prevent any delays in required inspections.	
K 511	Utilities - Gas and Electric	K 511		5/10/18

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	**04/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 511 SS=E	Continued From page 4 CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2. This deficient practice could effect 74 of the 74 residents. FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 4/05/18, items were observed directly in front of the electrical panel access doors in the Mechanical Room, FF-2 and the Storage Room, FF-2. This deficient practice was verified by the Facility Maintenance Director.	K 511	Badge swipe access to the electrical rooms is scheduled to be changed on 4/27/18 and locks/keys to be changed on the electrical rooms that do not have badge access. Changing the access will restrict unauthorized use of these rooms. The maintenance department will monitor the electrical rooms every month for three months and quarterly thereafter. Reports will be reviewed at the monthly quality meetings. Staff education on restricted access to electrical rooms will occur during staff meetings on 5/3/18 and 5/10/18	
K 914 SS=E	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101	K 914		5/15/18

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	245228	A. BUILDING **02 - NEW BUILDING AND RENOVATED EXISTING BLD** B. WING ______	**04/05/2018**

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K 914	Continued From page 5 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this	K 914	Electrical outlet checks were started on 4/11/18 and will be completed by 5/15/18. The receptacle test form (see attached) will be utilized when completing the checks and will be used to track compliance of the condition of the receptacles. Ongoing electrical outlet checks will occur annually and has been added to the maintenance book of business and outlook calendars.	

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	245228	A. BUILDING **02 - NEW BUILDING AND RENOVATED EXISTING BLD** B. WING ______	**04/05/2018**

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K 914	Continued From page 6 manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99). This deficient practice could effect the 74 out of 74 residents. FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 04/05/2018, it was revealed that not all of the testing procedures were being conducted during the electric receptacle testing. The electrical receptacles must receive the following inspections: 1.The physical integrity of each receptacle shall be confirmed by visual inspection. 2. The continuity of the grounding circuit in each electrical receptacle shall be verified. 3. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. 4. The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz). This deficient practice was verified by the Facility Maintenance Director.	K 914		