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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9H7F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00877

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245224**
2.STATE VENDOR OR MEDICAID NO.
(L2) **721522300**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA HEALTH CARE CENTER OF HASTINGS**
(L4) **930 WEST 16TH STREET**
(L5) **HASTINGS, MN** (L6) **55033**

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 **09/02/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **91** (L18)

13.Total Certified Beds **91** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	91			
(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 :
Susanne Reuss, Supervisor 09/09/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 09/09/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/06/1978
(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
08/19/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5224

September 9, 2014

Ms. Kay Emerson, Administrator
Augustana Health Care Center of Hastings
930 West 16th Street
Hastings, Minnesota 55033

Dear Ms. Emerson:

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 21, 2014, the above facility is certified for:

91 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 91 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring,
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 9, 2014

Ms. Kay Emerson, Administrator
Augustana Health Care Center of Hastings
930 West 16th Street
Hastings, Minnesota 55033

RE: Project Number S5224023

Dear Ms. Emerson:

On July 29, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 17, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 2, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 22, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 17, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 21, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 17, 2014, effective August 21, 2014 and therefore remedies outlined in our letter to you dated July 29, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245224	A. Building B. Wing	9/2/2014

Name of Facility	Street Address, City, State, Zip Code
AUGUSTANA HEALTH CARE CENTER OF HASTINGS	930 WEST 16TH STREET HASTINGS, MN 55033

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **08/12/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **08/12/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **08/12/2014**
ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **08/12/2014**	ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	Correction Completed **08/12/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	09/09/2014	16022	09/02/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 7/17/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245224	A. Building B. Wing **01 - MAIN BUILDING 01**	8/22/2014

Name of Facility	Street Address, City, State, Zip Code
AUGUSTANA HEALTH CARE CENTER OF HASTINGS	930 WEST 16TH STREET HASTINGS, MN 55033

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0029	Correction Completed **08/21/2014**	ID Prefix Reg. # **NFPA 101** LSC K0071	Correction Completed **08/20/2014**	ID Prefix Reg. # **NFPA 101** LSC K0144	Correction Completed **08/20/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/AK	**Date:** 09/09/2014	**Signature of Surveyor:** 25822	**Date:** 08/22/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 7/15/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**		**YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9H7F

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00877

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245224**

2.STATE VENDOR OR MEDICAID NO.
(L2) **721522300**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA HEALTH CARE CENTER OF HASTINGS**
(L4) **930 WEST 16TH STREET**
(L5) **HASTINGS, MN** (L6) **55033**

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 **07/17/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **91** (L18)

13.Total Certified Beds **91** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	91			
(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 :
Candace Bolduc, HFE NE II 08/11/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 08/19/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/06/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 08/19/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5309

July 29, 2014

Ms. Kay Emerson, Administrator
Augustana Health Care Center of Hastings
930 West 16th Street
Hastings, Minnesota 55033

RE: Project Number S5224023

Dear Ms. Emerson:

On July 17, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793
Fax: (651) 201-3790

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 August 26, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 26, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 17, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 17, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

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
	245224	A. BUILDING _____ B. WING _____	07/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF HASTINGS	930 WEST 18TH STREET HASTINGS, MN 55033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	"Augustana Health Care Center of Hastings" Plan of Correction is written credible ascertain of substantial compliance with the Federal and State requirements for Nursing facilities and/or skilled nursing facilities participating in the Federal Medicare or State Medical Assistance program. Please note that nothing set forth in this Document is to be or should be continued to be an admission by Augustana Health Care Center of Hastings or employee of Augustana Health Care Center of Hastings, of the validity or accuracy of any of the deficiencies cited by the Minnesota Department of Health relative to the survey, certification and enforcement effort at issue. Further, please note that any or all documents transmitted or otherwise provided by Augustana Health Care of Hastings in relations to this Plan of Correction, as well as any and all other communications in writing or otherwise by or on behalf of Augustana Health Care Center of Hastings are and shell be construed to be WITHOUT PREDJUDICE to the rights , remedies, claims, defenses of Augustana Health Care Center of Hastings, at law and/or in equity, all of which and not waived and all of which are reserves and retained by, for and on behalf of Augustana Health Care Center of Hastings.	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156		

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

Kay M Emerson — Administrator — 8/8/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245224	A. BUILDING _____ B. WING _____	07/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF HASTINGS	930 WEST 16TH STREET HASTINGS, MN 55033

(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 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the	F 156	Resident 111 and 159 have both discharged from the facility. Residents whose Medicare coverage will be ending will receive their liability notices and beneficiary appeal rights at least 48 hours prior to discharge from skilled services. The facility's policy was reviewed and updated where necessary. The Medicare Nurse, or her designee, have been re-inserviced on 8/1/2014 regarding the regulation and facility policy for issuance of liability notices. A copy of the liability notices will be provided to the Administrator for review to ensure that they were issued in an appropriate time frame. The Administrator will audit for compliance. Any issues noted with the process will be referred to the facility's QAPI Team for input/suggestions. The Administrator is responsible for ensuring that liability notices and beneficiary appeal rights are administered at least 48 hours prior to discharge from skilled services.	8/6/201

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AUGUSTANA HEALTH CARE CENTER OF HASTINGS	930 WEST 16TH STREET HASTINGS, MN 55033

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F 156	Continued From page 2 facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not provide 48 hour notice for end of Medicare coverage for 2 of 3 residents (R111, R159) reviewed for liability notices and beneficiary appeal rights. Findings include: Review of Notice of Medicare Provider Non-Coverage forms (CMS-10123) on 7/17/14, for R111 and R159 revealed these forms were not signed by recipients at least 48 hours prior to the end of their Medicare coverage in the facility. Medicare coverage for R111 ended on 5/30/14, and the notice was signed on 5/29/14. R111 was discharged home the next day. Medicare coverage for R159 ended on 6/13/14, and the notice was signed on 6/12/14. The resident was discharged to home the next day. During interview, On 7/17/14, at 11:20 a.m. the facility's Minimum Data Set (MDS) registered nurse (staff who handles the non-coverage	F 156		

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F 156	Continued From page 3 forms) thought a two day notice from discharge had to be given and not at end of service. The policy for Denial Letters, last reviewed 10/12, indicated under Procedural Step 4. B. 1: "When there is a change in the level of care: Medicare staff must notify the beneficiary when they no longer meet the coverage criteria. A denial notice must be issued a minimum of two-day notice."	F 156		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	Resident 120 has been discharged from the facility. Any event that is reportable under the State or Federal law will be reported immediately per regulation. Resident-to-resident altercations will be reported immediately to the Administrator. Resident-to-resident altercations will be reported per policy when the CMS/MDH criteria for reporting are met. Facility will also begin keeping a separate resident-to-resident event log to track resident-to-resident aggressive incidents. Licensed and management staff have been reinserviced on VA policy, reporting, and notification to Administrator of required incidents during 8/5/2014 – 8/9/2014. All staff has been re-inserviced on the facility's policy for VA protection and reporting requirements during the same time period. The administrator is responsible for ensuring that all reportable events are immediately reported to the Minnesota Department of Health and the Common Entry Point for vulnerable adults. *(CONTINUED ON NEXT PAGE)*	8/12/2014

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F 225	Continued From page 4 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all alleged violations involving resident to resident altercations were reported to the administrator immediately and/or reported to officials in accordance with state laws for 2 of 4 residents (R1, R2) who were reviewed. Findings include: R1 was involved in an incident with R120. Although the incident had been reported to the administrator, it had not been reported to the state agency, per facility policy. Review of a report dated 4/29/14, R1 and R120 were involved in an altercation. R120 had been admitted that day into the room with R1. At 8:45 p.m. two staff members heard someone yell, "get out" and then heard slapping sounds. As the staff members entered the room they saw R120 standing, holding onto the wheelchair with hand raised. R1 had warmth and redness to the left ear. R1 was identified in the quarterly minimum data set (MDS) dated 6/14, as non communicative, total care resident with no behavior problems. A decision was made for the immediate action taken to remove R1 from the	F 225	Augustana Care's Regional Director of Clinical Practice, or her designee, will audit VA files and the facility's resident-to-resident aggression log to ensure the facility is meeting regulatory guidelines. Issues/concerns noted will be referred to the facility's QAPI Team for input/ suggestions.	

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F 225	Continued From page 5 room and move to the first floor to spend the night in a different room, rather than moving R120. At approximately 9:30 p.m., the staff called the administrator to inform of the incident. The documentation on the incident report dated 4/30/14, revealed the administrator and director of nursing (DON) discussed reportability issues at 10:15 p.m. on 4/29/14, and felt the incident did not meet the criteria to report it. R120 was confused with no intent or question of intent, but more importantly no serious harm occurred to R1. Review of progress notes, dated 4/29/14, at 10:50 p.m. indentified R1 left the room he had been moved into for the night and took the elevator back upstairs. He was described as agitated, crying and upset. R1 did not want to leave his room but after the staff described the situation that had happened earlier, he agreed to sleep on first floor for the night. Although it had been determined that R120 was confused with no intent to harm R1, progress notes dated 4/30/14 at 10:44 a.m., indicated the administrator met with R120 to discuss the incident and when asked about the incident R120 said, "he annoyed me." There was no explanation given as to what R1 had done to annoy R120. The administrator indicated to R120 hitting others was not allowed under any circumstances. R120 then asked the administrator, "how's the other guy doing?" R120 said, "I will try my best not to hit anyone." The admission MDS dated 5/6/14, indicated R120 had a brief interview for mental status (BIMS) and scored a 12/15, indicating mild cognition deficits.	F 225		

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F 225	Continued From page 6 Progress notes on 4/30/14, at 1:15 p.m. indicated R1 was observed crying. R1 was notified would need to spend one more night out of his room and would return on 5/1/14, when R120 was moved to a private room. Attempts to interview R1 on 7/16/14, were unsuccessful. On 7/16/14, at 11:30 a.m., the administrator was interviewed about reporting of the incident to the state agency. The administrator felt there was no willful intent on the part of R120 due to dementia diagnoses and adjustment after being in the Grace Unit (a behavioral unit). The administrator explained that the facility uses an algorithm to determine if resident to resident altercations are willful. When asked what would R1 have done to annoy R120, the administrator stated did not know why R1 would annoy him because R1 annoys no one and has no behaviors. The administrator also indicated did not feel R120 understood what he was doing although it might seem like R120 did. The administrator further described R120 as a loner who wanted to self isolate and was easily agitated. The administrator reviewed the policy and said the policy indicated resident to resident abuse must be reported. Upon further interview at 12:21 p.m., the administrator indicated her understanding was there had to be intent which she did not think R120 had. She felt R120 was disconnected from reality and R1 was not seriously injured by the incident so it was not reported. The policy and procedure, titled Vulnerable Adult Reporting and Investigation Procedure revised on 8/13, indicated under the section: "incidents that must be reported immediately to the Minnesota	F 225		

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F 225	Continued From page 7 Department of Health (MDH)" included resident to resident abuse. The policy also indicated the administrator was to be notified immediately. R2 was involved in an incident with R120 and the incident was not reported to the administrator or state agency. An incident report, dated 5/10/14 at 7:10 p.m., revealed R2 and R120 were involved in an altercation. R2 was sitting in a wheelchair in the lounge on second floor. R120 was observed standing over R2 with hands raised and according to the written incident report, R120 slapped R2 on the right arm, face and neck. After the incident R120 was removed from the area and as R120 was being removed he slapped the nursing assistant (NA) in the face. There was no injury to R2 and R120 was sent into the Grace Unit. The administrator was not notified of the incident and the incident was not reported to the state agency. When interviewed on 7/16/14, at 11:30 a.m., the administrator indicated staff must always notify her right away and most often staff would notify the director of nursing (DON) as well. The administrator did not recall being notified of the incident on 5/10/14, and said the incident was not reported to the state agency. The administrator could not provide documentation as to why the incident between R2 and R120 was not reported.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit	F 226	Resident 120 has been discharged from the facility. *(CONTINUED ON NEXT PAGE)*	8/12/2004

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F 226	Continued From page 8 mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement their policy to report resident to resident altercations to the state agency for 2 of 4 residents (R1, R2) whose reports were reviewed and failed to immediately notify the administrator for R2. Findings include: The policy and procedure, titled Vulnerable Adult Reporting and Investigation Procedure revised on 8/13, indicated under the section: "Incidents that must be reported immediately to the Minnesota Department of Health (MDH)" included resident to resident abuse. The policy also indicated the administrator was to be notified immediately. On 7/16/14, at 11:30 a.m., the administrator was interviewed regarding a report dated 4/29/14, where R1 and R120 were involved in an altercation. R120 had been admitted that day into the room with R1. At 8:45 p.m. two staff members heard someone yell, "get out" and then heard slapping sounds. As the staff members entered the room they saw R120 standing, holding onto the wheelchair with hand raised. R1 had warmth and redness to the left ear. When asked why the report had not been called to the state agency, the administrator felt there was no willful intent on the part of R120 due to dementia diagnoses and adjustment after being in the Grace Unit (a	F 226	Any event that is reportable under the State or Federal law will be reported immediately per regulation. The facility's VA policy/procedure has been reviewed and updated as necessary. Staff was re-inserviced from 8/5/2014 – 8/9/2014 on the facility's policy and procedure for VA reporting including resident-to-resident aggression. Resident to resident altercations will be reported, per policy, when the CMS/MDH criteria for reporting are met. Facility will also begin keeping a separate resident-to-resident event log to track resident-to-resident aggressive incidents. Licensed and management staff have been reinserviced on VA policy, reporting, and notification to Administrator of required incidents. All staff has been re-inserviced on the facility's policy for VA protection and reporting requirements. The administrator is responsible for ensuring that all reportable events are immediately reported to the Minnesota Department of Health and the Common Entry Point for vulnerable adults. Augustana Care's Regional Director of Clinical Practice will audit VA files and the facility's resident-to-resident aggression log to ensure the facility is meeting regulatory guidelines. Issues/concerns noted will be referred to the facility's QAPI Team for input/suggestions.	

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F 226	Continued From page 9 behavioral unit). Administrator indicated did not feel R120 understood what he was doing, although, "[R120] may seem like he did but he does not". The administrator reviewed the policy and said the policy stated resident to resident abuse must be reported to the state agency. Administrator was also interviewed at this time regarding the incident with R2 and R120 that occurred 5/10/14 at 7:10 p.m. The report revealed R2 was sitting in a wheelchair in the lounge on second floor and R120 was observed standing over R2 with hands raised. According to the written incident report, R120 slapped R2 on the right arm, face and neck. After the incident R120 was removed from the area and as R120 was being removed he slapped the nursing assistant (NA) in the face. The administrator stated that staff must always notify her right away and most often staff would notify the director of nursing (DON) as well. The administrator did not recall being notified of the incident on 5/10/14, or of it being reported to the state agency. The administrator could not provide documentation as to why the incident between R2 and R120 was not reported.	F 226		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.	F 246	Resident 20, 45, and 55 all have their call lights within reach. All residents have either the stand call light or a flat call light within reach in their respective rooms. Resident's care plans have been reviewed and updated as necessary. Staff was re-inserviced from 8/5/2014 – 8/9/2014 on the facility's policy for having the call light within reach. *(CONTINUED ON NEXT PAGE)*	8/12/2014

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F 246	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 3 of 3 residents (R20, R45, R55) call lights were at reach reviewed for environmental concerns. Findings include: R20's call light was not accessible on 7/14/14, at 4:52 p.m. R20 was observed sitting in wheel chair (w/c) near window in room and the call light was observed hanging down from wall, few inches of cord seen hanging down from panel, with call light push button unseen, out of reach and unavailable for R20 to access. NAR-D at 4:54 p.m. verified that call light push button was unseen and unreachable between wall and mattress for R20. NAR-D stated R20 was able to use the call light and R20 needed staff assistance for transferring. During the environmental tour on 7/17/14, at 1:09 p.m., R20 was observed sitting in w/c playing cards on night table with call light nearby in nightstand top drawer. The administrator verified R20's call light should be within reach while R20 is in room. R45's call light was not at reach on 7/14/14, at 4:17 p.m. R45 was observed sitting in recliner in room with no call light within reach. A call light was hooked on R45's bed and another one was hooked on the couch. Both call lights were out of reach for R45 to access. Surveyor called NAR-C to room and NAR-C verified call light placements out of reach for R45 to access while sitting in recliner. NAR-C stated R45 was able to use the	F 246	Audits will be done three times per week, on different shifts, by assigned staff to ensure that call lights and call light clips are within reach in every resident room. Any noted issue will be forwarded to the applicable nurse manager for appropriate follow up with the staff. Call light audits will be brought to the facility's QAPI meeting for input/ suggestions from the Team. The Administrator is responsible for ensuring that call lights are within reach for residents.	

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F 246	Continued From page 11 call light and R45 required staff assistance to walk. During the environmental tour on 7/17/14, at 1:05 p.m. R45 was observed lying in bed with call light placed on bed rail, within reach. The administrator verified R45 should have call light within reach when R45 is in room. R55's call light was not accessible on 7/14/14, 7/15/14, and 7/16/14. R55's call light was observed lying on the floor under R55's bed, out of reach for R55 to safely access. On 7/14/14, at 7:04 p.m., R55 was observed sitting on the bed. R55's call light was lying on the floor under R55's bed, out of sight for R55 to access. Surveyor called NAR-D to room and NAR-D verified that R55's call light was lying on the floor under R55's bed and unable for R55 to find. NAR-D picked up call light and set call light on top of R55's bed. The call light slipped off the bed and NAR-D again picked up call light and put it on top of R55's pillow on bed, without clipping to pillow. NAR-D stated R55 was able to use the call light and R55 should have assistance from staff when transferring to w/c. On 7/15/14 at 8:20 a.m., R55 was observed sitting in a chair at the end of the hall alone with no staff in sight. R55 was fidgity, looking around and asking for toileting help. At 8:22 a.m., staff approached R55 and R55 stated, "I have to go to the bathroom." NAR-E indicated R55 flags staff down when sitting in the hall. On 7/16/14, at 8:58 a.m., call light for R55 was observed lying on top of bed unclipped. At 1:15	F 246		

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	245224	A. BUILDING _____ B. WING _____	07/17/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF HASTINGS	930 WEST 16TH STREET HASTINGS, MN 55033

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F 246	Continued From page 12 p.m., R55 was observed sitting on top of bed with w/c 3-4 feet away from bed, facing away from bed. R55 was attempting to grasp the w/c handles, and said, "I want to get into my chair." When asked where the call light was, R55 stated, "I don't know where my call light is." Surveyor notified staff and and at 1:17 p.m., NAR-B verified R55's call light was on the floor, under the bed and not in reach or view for R55. NAR-B stated "It must have fallen to the floor, let me clip it so it doesn't fall. Oh the clip is broke". NAR-B assisted R55 to w/c and stated she would go get a new clip and fix it. At 1:30 p.m., R55's call light was observed clipped on the top of R55's bed. On 7/17/14, at 8:44 a.m., RN-A stated that a bell will be set beside R55 when sitting in the hall so that R55 could access it when she needed help from staff. RN-A also stated occupational therapy would be doing an assessment for R55's ability to use the bell. At 9:58 a.m., RN-A said occupational therapy stated R55 did well with using the bell on a trial run. R55 verbalized being able to use the bell. During the environmental tour on 7/17/14, at 1:11 p.m., R55 was observed sitting in w/c in hall near staff. R55's call light was observed clipped on top of R55's bed. The administrator verified R55's call light should be secured to bed and within R55's reach to safely access instead of the call light lying on the floor under bed. On 7/16/14, at 2:35 p.m. RN-A stated to surveyor, "I will follow up on the call lights and do some education" in this unit. On 7/17/14, at 8:44 a.m., RN-A stated she had done a call light audit on the unit for call light	F 246		

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F 246	Continued From page 13 placement, some staff education, and careplan and aides sheets had been updated. Facility's policy titled Call Lights New Call Light System, Revision Date: 07/14 reads Resident will have a means of contacting staff to obtain assistance at all times. On the policy under procedural step number 2 reads Place call light so it is accessible to the resident at all times. Secure the call light to stay within access of the resident.	F 246		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure residents or resident representatives received notice before a roommate change for 2 of 3 residents (R44, R95) who had a roommate change. Findings include: R44 and R95 received new roommates and no notice was given prior to the move. R44 was interviewed on 7/14/14, at 7:05 p.m. and when asked about having a new roommate recently, replied she did have a new roommate. When R44 was asked as to whether she was given notice about a new roommate and did not believe she had been given a notice. She said,	F 247	Residents 44 and 95 have adjusted to their new roommate assignments. Residents, and/or, their representative will be notified prior to receiving a new roommate. This notification will be conducted verbally and will documented in the resident's EMR. Both social workers were re-inserviced on the regulation and policy regarding roommate notification on 7/31/2014. Licensed staff and facility management team were inserviced on roommate notification requirements between 8/5/2014 and 8/9/2014. The room change notice (internal document) utilized as a checklist for room changes has been reviewed and modified to include notification of new roommates. Licensed staff and facility management will ensure notification of new roommates occur during the evening/ NOCs/weekends. *(CONTINUED ON NEXT PAGE)*	8/12/2014

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F 247	Continued From page 14 "you just expect it." R95's family member (FM)-A was interviewed on 7/15/14, at 11:50 a.m. and when asked about a new roommate FM-A indicated R95 received a new roommate about six months ago. When asked whether given a notice about the move FM-A did not recall being given notice. When interviewed on 7/17/14, at 9:40 a.m. the social worker (SW)-A indicated R44 had several roommates recently due to death but was unable to find documentation to indicate R44 had been given notice of a new roommate. For R95, SW-A was also unable to find any indication that notice of a roommate change had been given to FM-A. SW-A agreed all residents should be given notice. The policy and procedure titled Transfers: Resident Rooms, dated 7/14, indicated the resident or the designated responsible person will be notified in writing seven days prior to the in house transfer by social service.	F 247	The Administrator will audit the EMR of all resident's receiving new roommates to ensure proper notification was completed. The Administrator is responsible for ensuring that residents are notified of a new roommate. Issues with roommate notification will be referred to the facility's QAPI meeting for input/suggestion from the Team.	

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

F5224022

PRINTED: 07/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245224	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA HEALTH CARE CENTER OF HASTINGS	930 WEST 16TH STREET HASTINGS, MN 55033

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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, Augustana Health Care Center of Hastings 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	K 000	POC ok 8-11-14 RECEIVED AUG - 8 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Exit: 7-17-14 DC: 8-26-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kathy M Emerson-Schmaltz	Administrator	8/8/14

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

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K 000	Continued From page 1 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Augustana Health Care Center of Hastings is a 2-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1967 and was determined to be of Type II(111) construction. In 1973, and 1992 an addition(s) was constructed to the building that was determined to be of Type II(111)construction. Because the original building and the addition(s) meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled. 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 licensed capacity of 92 beds	K 000		

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K 000	Continued From page 2 and had a census of 74 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 22 out of 74 residents. Findings include: On facility tour between 8:15 AM and 11:15 AM on 07/15/2014, observation revealed that the following was found: 1. 1st floor - Maintenance Shop - open penetration on west wall around 4 inch pipe	K 029		

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K 029	Continued From page 3 2. 1st floor - Boiler room - open penetrations on south wall around 2 inch pipe 3. 1st floor - Activities storage room (over 50 sq. ft.) open penetrations on south and west walls - around cables and pipes 4. 1st floor - Storage room - (over 50 sq. ft.) across from room #107, will not shut and latch 5. Ground floor - mechanical room - open penetration next to door frame These deficient practices were confirmed by the Facility Maintenance Director (KV) at the time of discovery.	K 029	The noted penetrations have all been resealed with fire-caulk. Administrator and Maintenance Director complete a monthly facility tour to evaluate and assess compliance with smoke barrier penetrations. The Maintenance Director is responsible for ensuring compliance with smoke barrier penetrations.	8/21/2014
K 071 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use.	K 071	The parts for the laundry chute latches are on order Administrator and Maintenance Director complete a monthly facility tour and will check the laundry chutes for proper closure. Additionally, staff were inserviced between 8/5/2014 and 8/9/2014 on informing Maintenance if/when there are issues with proper closure. The Maintenance Director is responsible for ensuring that the laundry chutes latch properly.	8/20/2014

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K 071	Continued From page 4 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observations, the facility has a laundry chute that does not meet the requirements of Sections 19.5.4, 9.5 and 8.4 and NFPA 82. This deficient practice could affect 74 residents Finding Include: On facility tour between 8:15 AM and 11:15 AM on 07/15/2014, observation revealed, that the 1st and 2nd floor soiled linen chute doors do not latch. These deficient practices were confirmed by the Facility Maintenance Director (KV) at the time of discovery.	K 071		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 8.4.4.1. This STANDARD is not met as evidenced by:	K 144	The generator service contractor (Cummins NPOWER) is scheduled to come to the facility on 8/20/2014 to complete the 2 hour load bank test. Maintenance Director spoke with the company on 7/12/2014 regarding their failure to comply with regulations. Maintenance Director is responsible for ensuring that the company complies with the regulations regarding the load bank test.	8/20/2014

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K 144	Continued From page 5 Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 6-4.2 (a) & (b) and 6-4.2.2. The deficient practice could affect all 74 residents. Findings Include: On facility tour between 8:15 AM and 11:15 AM on 07/15/2014, documentation review of the annual 2 hour load bank test from Cummins, dated 08/22/2013, of the diesel emergency generator was not run under the required loads (first 30 minutes - 25%, next 30 minutes - 50%, and last 1 hour - 75%). The report indicated the following: First 30 minutes = 24.6% next- 30 minutes = 49.7% last 1 hour = 74.3%, 74.5% and when transferred back was at 89.6% This deficient practice was confirmed by the facility Maintenance Director (KV) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 144		