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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: A6US

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00298

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245368**

2.STATE VENDOR OR MEDICAID NO.
(L2) **304340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRAND VILLAGE**
(L4) **923 HALE LAKE POINTE**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

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 **04/18/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **119** (L18)

13.Total Certified Beds **119** (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
	119			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jane Aandal, HFE NE II 05/29/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 05/29/2013 (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
11/01/1986
(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 5/31/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/08/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5368

At the time of the standard survey completed February 14, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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 are required. The facility was given an opportunity to correct before remedies were imposed.

On April 18, 2013, the Minnesota Department of Health and, on April 4, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on February 14, 2013, effective March 27, 2013. Therefore, the remedies outlined in our letter dated March 4, 2013, will not be imposed.
See attached CMS-2567B forms for the results of the April 18, 2013 and April 4, 2013 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5368 May 29, 2013

Ms. Shawna Jokinen, Administrator
Grand Village
923 Hale Lake Pointe
Grand Rapids, Minnesota 55744

Dear Ms. Jokinen:

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 March 27, 2013 the above facility is certified for:

119 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 119 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,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 29, 2013

Ms. Shawna Jokinen, Administrator
Grand Village
923 Hale Lake Pointe
Grand Rapids, Minnesota 55744

RE: Project Number S5368023

Dear Ms. Jokinen:

On March 4, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 14, 2013. 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 April 18, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on April 4, 2013 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 February 14, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 27, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 14, 2013, effective March 27, 2013 and therefore remedies outlined in our letter to you dated March 4, 2013, 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,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5368r113.rtf

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245368	A. Building B. Wing	4/18/2013

Name of Facility	Street Address, City, State, Zip Code
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

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 **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/26/2013**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/26/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **03/26/2013**
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	Date:	Signature of Surveyor:	Date:
	PK/sd	05/29/13	11349	04/18/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/14/2013			

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
245368	A. Building B. Wing **01 - MAIN BUILDING 01**	4/4/2013

Name of Facility	Street Address, City, State, Zip Code
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

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 K0056	Correction Completed **02/19/2013**	ID Prefix Reg. # **NFPA 101** LSC K0144	Correction Completed **03/27/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/sd	**Date:** 05/29/13	**Signature of Surveyor:** 03006	**Date:** 04/04/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 2/13/2013		**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
245368	A. Building B. Wing 02 - SUB ACUTE	4/4/2013

Name of Facility	Street Address, City, State, Zip Code
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

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 K0144	Correction Completed 03/27/2013	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/sd	Date: 05/29/13	Signature of Surveyor: 03006	Date: 04/04/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/13/2013		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: A6US

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00298

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245368**

2.STATE VENDOR OR MEDICAID NO.
(L2) **304340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GRAND VILLAGE**
(L4) **923 HALE LAKE POINTE**
(L5) **GRAND RAPIDS, MN** (L6) **55744**

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 **02/14/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **119** (L18)

13.Total Certified Beds **119** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	119			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFE-NEII 03/27/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 04/05/2013 (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
11/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

At the time of the standard survey completed on February 14, 2013, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed.

See attached CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 9677

March 4, 2013

Ms. Shawna Jokinen, Administrator
Grand Village
923 Hale Lake Pointe
Grand Rapids, Minnesota 55744

RE: Project Number S5368023

Dear Ms. Jokinen:

On February 14, 2013, 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:

Pam Kerssen
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858

Telephone: (218) 308-2129

Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 26, 2013, 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 March 26, 2013 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 May 14, 2013 (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 August 14, 2013 (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,

Pam Kerssen, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2129 Fax: (218) 308-2122

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
	245368	A. BUILDING _____ B. WING _____	02/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	923 HALE LAKE POINTE GRAND RAPIDS, MN 55744

(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		3.26.13
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	F-279 SS=D 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS Grand Village does use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. Grand Village does develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan does describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being 1. Corrective Action: A. Immediate Care Plan updates 2/14/2013 for resident # 4 to include emergency services related to coordinated care;	3-12-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shawna Jokinen | TITLE: Administrator | (X6) DATE: 3/15/13

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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F 279	Continued From page 1 by: Based on interview and document review, the facility failed to develop and implement care planning interventions including emergency procedures related to coordinated care for 1 of 1 resident (R4) who received dialysis services. In addition, the facility failed to develop care plan interventions for 2 of 3 residents (R30, R76) who required contact precautions for Clostridium difficile infections (CDI, is a species of Gram-positive bacteria which causes severe diarrhea and other intestinal disease when competing bacteria in the gut have been wiped out by antibiotics). Findings include: R4's plan of care did not include directions for emergency procedures related to hemodialysis. R4 had multiple diagnoses which included chronic kidney disease and hemodialysis dependent. The annual Minimum Data Set (MDS) dated 12/31/12, identified R4 as being cognitively alert and orientated, requiring extensive assistance with all activities of daily living (ADLs) and as receiving hemodialysis three days a week. The plan of care dated 9/21/12, identified R4 as having potential for complications related to hemodialysis. The plan directed staff to check the dialysis fistula each shift for thrill/bruit, monitor the site for redness and to remove the dialysis dressing two hours after returning to the facility. The plan of care did not include emergency procedures related to dialysis concerns such as, what to do if the resident was unable to go to dialysis or what to do if the resident's fistula	F 279	short term care plans were immediately put in place on 2/14/2013, for resident #'s 30 and 76 who were actively being treated and did have PPE positioned for contact precaution guidelines. 2. Corrective Action as it applies to Other Residents: A. Nurse Managers conducted a review of Comprehensive Care Plans and implemented short term Care Plans where need was identified. B. The policy for Comprehensive Care Plans and implementation of short term Care Plans was reviewed, no changes were required. Licensed Nursing Team re-educated 2/15/2013. 3. Date of Completion: 2/15/13 4. Reoccurrence will be Prevented by: A. Licensed Nursing Team re-educated 2/15/2013, as per Nursing education and Board of Nursing requirements, protocol for Grand Village upon hire, annually, and as needed. B. Review of comprehensive care plans will be conducted at least quarterly and updated as needed. Review of short term	

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F 279	Continued From page 2 began to bleed or display other difficulties. On 2/14/13, at 10:00 a.m. registered nurse (RN) -B reviewed R4's plan of care and confirmed the plan did not address emergency procedures related to dialysis. R30 did not have a plan of care related to CDI. R30 had multiple diagnoses which included status post hospitalization for pneumonia. The admission MDS dated 1/15/13, identified R30 as being cognitively intact, requiring extensive assistance with ADLs and as being frequently incontinent of stools. The laboratory results dated 1/15/13, identified R30 was positive for CDI. The plan of care dated 1/29/13, did not include infection control instructions on how to care for CDI. On 2/13/13, at 12:57 p.m. RN-B confirmed R30's plan of care did not direct staff how to care for R30 while the resident had CDI. R76's did not have a plan of care related to CDI. R76 had a diagnosis including CDI. The admission MDS dated 1/25/13, identified R76 as alert and orientated, requiring extensive assistance with all ADLs and as being frequently incontinent of bowel. The hospital discharge summary dated 2/4/13, revealed on 1/26/13, R76 was admitted to the hospital with a diagnosis of acute CDI. Upon returning to the facility on 2/4/13, R76 continued	F 279	problems (less than 30 days) will be reviewed by IDT at morning stand up meetings Monday through Friday. 5. The Correction will be Monitored by: A. DON or designee (Nurse Managers/MDS Nurses) B. The DON/designee will monitor compliance weekly x 4, then monthly by DON or designee, with review at the Quality Assurance meeting C. Responsible Person: Director of Nursing D. Date Certain: 3-26-2013	

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F 279	Continued From page 3 to receive Flagyl 500 milligrams (mg) (treat CDI) three times a day for seven days and Vancomycin 250 mg four times a day for ten days. R76's plan of care dated 1/15/13, did not address infection control precautions related to CDI. Review of the undated policy entitled Clostridium difficile (C-diff) Protocol, directed the staff to start a temporary care plan to assist in directing the care for CDI. On 2/13/13, at 1:45 p.m. RN-A/unit manager confirmed the plan of care did not address CDI. RN-A verified the facility policy had not been followed.	F 279		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format.	F 356	F 356 SS=C 483.30(e) POSTED NURSE STAFFING INFORMATION Grand Village will post the following information on a daily basis: • Facility name. • The current date. • The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. • Resident census. Grand Village will post the nurse staffing data specified above on a daily basis at the beginning of each shift.	3-26-13

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F 356	Continued From page 4 o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post the total number and the actual hours worked for nursing staff directly responsible for resident care per shift. In addition, throughout the survey, the hours were not observed posted in a prominent place readily accessible to residents and visitors. This practice had the potential to affect 115 of 115 residents residing in the facility. Findings include: On 2/11/13, at 1:30 p.m. during the initial tour of the facility, a nurse staff posting form was observed hanging on the wall in the hallway away from the main entrance to the facility. The posted nurse staffing information lacked the total number and the actual hours worked per shift by the licensed and unlicensed nursing staff directly responsible for resident care. In addition, the nurse staff posting form had the incorrect date of 2/7/13, on it and was posted too high on the wall for residents to view it from their wheelchairs.	F 356	Data must be posted as follows: • Clear and readable format. • In a prominent place readily accessible to residents and visitors. 1. Corrective Action: A. Grand Village has revised the Posted Nurse staffing information form in a more clear and readable format and lowered to a prominent place readily accessible to residents and visitors on 02-15-2013. 2. Corrective Action as it applies to other residents: A. Revised form B. Lowering of the data to allow for wheel chair accessibility to residents and visitors 3. Date of Completion 02/15/2013 4. Reoccurrence will be Prevented by: A. Nursing Team re-educated 2/15/2013 5. The Correction will be Monitored by: A. The DON/designee will monitor the location and contents of the documentation weekly x 4, then monthly by DON or designee, with review at the Quality Assurance meeting B. Responsible Person: Director of Nursing C. Date Certain: 3-26-2013	

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F 356	Continued From page 5 The Nurse Staff Posting form dated 2/7/13, indicated the facility reported the number and shift the licensed and unlicensed staff were scheduled to work. However, the form did not indicate the actual total number of hours worked for licensed and unlicensed nursing staff. On 2/11/13, at 1:35 p.m. the administrator verified the nurse staff posting was incorrectly dated and lacked the total number of hours worked by licensed and unlicensed staff. The administrator also acknowledged the height of the nurse posting form would be difficult for residents in wheelchairs to see.	F 356		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	F 431	F 431 SS=D 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS Grand Village contracts for the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled and proper disposal of used Fentanyl Patch per manufactures recommendations. 1. Corrective Action: A. Immediate MAR updates on 2/14/2013 for resident # 28, # 32 and # 44 to reflect 2 person sign off for the	3-14-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 6 have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow currently accepted principles for disposal of controlled substances for 3 of 3 residents (R28, R44, R32) who were prescribed Fentanyl patches. Findings include: During medication storage review conducted on 2/14/13, at 9:30 a.m. licensed practical nurse (LPN)-G and LPN-B both verified used Fentanyl patches prescribed to residents were routinely disposed of by folding the used patch and placing it into a sharps container on the medication cart. The full sharps containers were then placed in a utility/equipment room until picked up by the waste vendor. LPN-G reported there were three residents in the facility that were currently prescribed Fentanyl patches: R28, R44, and R32.	F 431	removal of a used Fentanyl patch and proper disposal instructions. 2. Corrective Action as it applies to other residents: A. 100 % record review and correction to one additional MAR. 3. Date of Completion 02/15/2013 4. Reoccurrence will be Prevented by: A. Education to all Team Leaders (TMA, LPN, RN) and Medical Records to automatically be entered upon admission or new order process for Fentanyl patch. 5. The Correction will be Monitored by: A. The DON/designee will monitor the location and contents of the documentation weekly x 4, then monthly by DON or designee, with review at the Quality Assurance meeting B. Responsible Person: Director of Nursing C. Date Certain: 3-26-2013	

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F 431	Continued From page 7 During interview with the director of nursing (DON) on 2/14/13, at 1:15 p.m. the DON verified the pharmacy consultant had been in the facility and provided education regarding the proper destruction of Fentanyl patches. The DON stated the pharmacy consultant had recommended the facility develop and adopt the policy of witnessed destruction of the Fentanyl patches, but indicated they had not developed a policy yet. A Centers for Medicare/Medicaid Services (CMS) Survey and Certification Group memo dated 11/2/12, identified facility policy should address safe handling, distribution and disposition of controlled medications to prevent diversion. Additionally, the facility policy, Controlled Substances-Counting policy dated/reviewed 5/2011, did not address storage methods for these controlled medications awaiting final disposition or documentation of final disposition consistent with current standards of practice.	F 431		

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	245368	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/13/2013**

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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 ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. 01 Main Building (1900, 1972, 1992 and 2000 additions) A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Grand Village 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145	K 000	POC ok JB 3-27-13	

DC: 03.26.2013

EXIT: 02.14.2013

RECEIVED
MAR 18 2013
MN DEPT. OF PUBLIC SAFETY
FIRE MARSHAL DIV.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shauna Jokinen	Administrator	3/15/13

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 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us and Barbara.Lundberg@state.mn.us Fax Number 651-215-0525 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 Grand Village was built in 5 different stages. The original building was built in the early 1900's of which only a small 1-story portion remains. It is Type II (222) construction and is separated from all other additions by at least 2-hour fire rated barriers. In 1972 a 1-story addition, without a basement, was constructed to the south of the existing building and was determined to be Type II (000) construction. In 1992, two 1-story additions, without basements, were constructed. One to the south of the 1972 building's west wing and one to the west of the 1972 building. Both addition were determined to be Type II (000) construction. The upper levels of the 1900's building were no longer used for healthcare. The 1992 west addition is separated from the rest of the building with 2-hour fire barriers. In 2000 the	K 000		

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K 000	Continued From page 2 laundry/kitchen addition was constructed in between the original building and the 1992 west addition. It is 1-story, without a basement and is Type II (111) construction. In 2004 the Sub-acute building was constructed to the north of the original building with the majority of the 1900's original building raised. It is 1-story, without a basement, was determined to be Type V (111) construction and is separated by 2-hour fire rated barriers. In 2011 a connecting link between the 1992 additions was created. The building is divided into 12 smoke zones with 1/2 hour and 1 hour fire rated barriers. The entire building is protected by two automatic fire sprinkler systems in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a manual fire alarm system with smoke detectors through the corridor system and detection in areas open to the corridor in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). Hazardous areas have automatic fire detectors that are on the fire alarm system and all sleeping rooms have single station smoke detectors that alarm outside the rooms and at the nurse's station that serves that room in accordance with the Minnesota State Fire Code (2007 edition). Because the original building and its additions are conforming structures for Existing Health Care and the 2004 Sub-acute building and the 2011 link was constructed to meet New Healthcare, this facility was surveyed as two buildings. The facility has a capacity of 119 beds and had a census of 116 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/13/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE** **GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 3 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	Tag K56	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Observations indicated that the automatic sprinkler system is not in accordance with NFPA 13 Standard for The Installation of Sprinkler Systems, 1999 edition. These deficient practices may allow a fire to grow which will negatively impact all the residents, visitors and staff. Findings include: During the facility tour on February 13, 2013, between 10:00 am and 12:30 pm, observations by surveyor 003006, revealed that various ceiling tiles throughout the facility have been removed or are missing including the electrical panel room, the business office, the gift shop storage room and room 1315.	K 056	Correction Ceiling tile was replaced in the business office, gift shop storage, and room 1315 on 2/13/13. Ceiling tile was replaced in electrical room on 2/19/13 Monitoring Maintenance software to prompt environmental staff to check facility wide for tiles out of place.Also remind contractors to replace tiles after work is complete. Responsible person Director of environmental services	

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	245368	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/13/2013**

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GRAND VILLAGE	**923 HALE LAKE POINTE GRAND RAPIDS, MN 55744**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 4 The Maintenance staff (SL) verified this finding during the facility tour and at the exit conference.	K 056	Tag K144 Correction	
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. 3.4.4.1. This STANDARD is not met as evidenced by: Observations revealed that the emergency generator is not tested in accordance with NFPA 110 The Standard for Emergency and Standby Power Systems 1999 edition section 6-4.2. This deficient practice could allow the generator to have a problem that would go unnoticed by staff which could negatively impact the all residents, visitors and staff. Findings include: Prior to the facility tour on February 13, 2013, at approximately 9:45 am, a review of the generator logs for Grand Village for 2011/ 12 and an interview with the Director of Maintenance (SL) revealed that the generator was run monthly under load, but is was not 30 percent of its nameplate rating as required by NFPA 110. No documentation of an annual load bank test was available for review.	K 144	Generator will be load bank tested annually on or before ~~5/1/13~~ 3-27-13 Measures Grand village has a 3 year contract with I.R.C. electrical to perform a 4 hour load bank test on generator. Monitoring Maintenance software to prompt environmental services staff and also contractor. Responsible person Director of environmental services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/13/2013**

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K 144	Continued From page 5 The Maintenance staff (SL) verified this finding during the facility tour and at the exit conference.	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**02/13/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRAND VILLAGE	**923 HALE LAKE POINTE GRAND RAPIDS, MN 55744**

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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 ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. 02 Sub-Acute 2004 Building A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Grand Village 02 Sub-Acute 2004 Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	POC ok JB 3-27-13	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shauna Jokinen — TITLE: Administrator — (X6) DATE: 3/15/13

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
	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**02/13/2013**

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K 000	Continued From page 1	K 000		

Or by e-mail to:
Marian.Whitney@state.mn.us and
Barbara.Lundberg@state.mn.us

Fax Number 651-215-0525

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

Grand Village was built in 5 different stages. The original building was built in the early 1900's of which only a small 1-story portion remains. It is Type II (222) construction and is separated from all other additions by at least 2-hour fire rated barriers. In 1972 a 1-story addition, without a basement, was constructed to the south of the existing building and was determined to be Type II (000) construction. In 1992, two 1-story additions, without basements, were constructed. One to the south of the 1972 building's west wing and one to the west of the 1972 building. Both addition were determined to be Type II (000) construction. The upper levels of the 1900's building were no longer used for healthcare. The 1992 west addition is separated from the rest of the building with 2-hour fire barriers. In 2000 the laundry/kitchen addition was constructed in

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	245368	A. BUILDING **02 - SUB ACUTE** B. WING _____	**02/13/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 2 between the original building and the 1992 west addition. It is 1-story, without a basement and is Type II (111) construction. In 2004 the Sub-acute building was constructed to the north of the original building with the majority of the 1900's original building raised. It is 1-story, without a basement, was determined to be Type V (111) construction and is separated by 2-hour fire rated barriers. In 2011 a connecting link between the 1992 additions was created. The building is divided into 12 smoke zones with 1/2 hour and 1 hour fire rated barriers. The entire building is protected by two automatic fire sprinkler systems in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a manual fire alarm system with smoke detectors through the corridor system and detection in areas open to the corridor in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). Hazardous areas have automatic fire detectors that are on the fire alarm system and all sleeping rooms have single station smoke detectors that alarm outside the rooms and at the nurse's station that serves that room in accordance with the Minnesota State Fire Code (2007 edition). Because the original building and its additions are conforming structures for Existing Health Care and the 2004 Sub-acute building and the 2011 link was constructed to meet New Healthcare, this facility was surveyed as two buildings. The facility has a capacity of 119 beds and had a census of 116 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 3 NOT MET as evidenced by:	K 000		
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. 3.4.4.1. This STANDARD is not met as evidenced by: Observations revealed that the emergency generator is not tested in accordance with NFPA 110 The Standard for Emergency and Standby Power Systems 1999 edition section 6-4.2. This deficient practice could allow the generator to have a problem that would go unnoticed by staff which could negatively impact the all residents, visitors and staff. Findings include: Prior to the facility tour on February 13, 2013, at approximately 9:45 am, a review of the generator logs for Grand Village for 2011/ 12 and an interview with the Director of Maintenance (SL) revealed that the generator was run monthly under load, but is was not 30 percent of its nameplate rating as required by NFPA 110. No documentation of an annual load bank test was available for review. The Maintenance staff (SL) verified this finding during the facility tour and at the exit conference.	K 144	Tag K144 Correction Generator will be load bank tested annually on or before 5/1/13 Measures Grand village has a 3 year contract with I.R.C. electrical to perform a 4 hour load bank test on generator. Monitoring Maintenance software to prompt environmental services staff and also contractor. Responsible person Director of environmental services	