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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: B0R1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00110

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245510**

2.STATE VENDOR OR MEDICAID NO.
(L2) **414490000**

3. NAME AND ADDRESS OF FACILITY
(L3) **EVANSVILLE CARE CENTER**
(L4) **649 STATE STREET NORTHWEST**
(L5) **EVANSVILLE, MN** (L6) **56326**

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) **09/23/2009**

6. DATE OF SURVEY **11/17/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 12/01/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 12/01/2017 (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
01/01/1988
(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
11/29/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245510 December 1, 2017

Mr. Brandon Borgstrom, Administrator
Evansville Care Center
649 State Street Northwest
Evansville, MN 56326

Dear Mr. Borgstrom:

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 November 30, 2017 the above facility is recommended for:

40 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 1, 2017

Mr. Brandon Borgstrom, Administrator
Evansville Care Center
649 State Street Northwest
Evansville, MN 56326

RE: Project Number S5510028

Dear Mr. Borgstrom:

On October 17, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 5, 2017. 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 November 17, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 30, 2017 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 October 5, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 30, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 5, 2017, effective November 30, 2017 and therefore remedies outlined in our letter to you dated October 17, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: B0R1

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(L3) **EVANSVILLE CARE CENTER**
(L4) **649 STATE STREET NORTHWEST**
(L5) **EVANSVILLE, MN** (L6) **56326**

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) **09/23/2009**

6. DATE OF SURVEY **10/05/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE - NE II 10/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 11/20/2017 (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
01/01/1988
(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 17, 2017

Mr. Brandon Borgstrom, Administrator
Evansville Care Center
649 State Street Northwest
Evansville, MN 56326

RE: Project Number S5510028

Dear Mr. Borgstrom:

On October 5, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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 November 14, 2017, 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 November 14, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 5, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 5, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

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
	245510	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE CARE CENTER	649 STATE STREET NORTHWEST EVANSVILLE, MN 56326

(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 On 10/2/17 thru 10/05/2017, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's electronic Plan of Correction (ePoC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePoC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the PoC will be used as verification of compliance.	F 000		
F 465 SS=E	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide appropriate maintenance to ensure a sanitary environment in 4 of 4 resident rooms (#109, #110, #127, #130)	F 465	F 465 Each item was individually addressed as brought up in the findings from the 2567.	11/14/17

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

Electronically Signed | 10/24/2017

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
	245510	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE CARE CENTER	649 STATE STREET NORTHWEST EVANSVILLE, MN 56326

(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 465	Continued From page 1 reviewed with needed repairs. Findings include: On 10/05/17, from 12:16 p.m. to 12:23 p.m. a tour of the facility was conducted with the environmental maintenance director (EMD). The EMD verified the following resident room concerns: ·Room 109, room walls and closet doors had several areas with gouges, approximately three inches to 10 inches in size, and missing paint in the gouges. ·Room 110, several approximately two inch size gouges in flooring in room and several holes in wall with exposed sheetrock, next to sink. ·Room 127, all four walls in bathroom had multiple gouged areas, approximately 10 inches in length, with exposed sheetrock and missing paint, multiple holes in bathroom wall near the paper towel holder. ·Room 130, bathroom faucet and handles corroded with a white substance, toilet tank cover cracked, which extended the entire width of the cover. The EMD confirmed the gouges and areas of missing paint identified in the rooms listed above were obvious and needed to be repaired. On 10/05/17, at 12:08 p.m. the EMD confirmed he had not received work orders requesting repairs for the above concerns identified. The EMD reported all staff were expected to notify the maintenance department when repairs were needed by making an entry in the Maintenance Request book located at the nurses station, which he checked daily. The EMD stated the usual	F 465	In room 109 the gouges were fixed in the closet door and room walls. They were then repainted. In the room 110 the gouges were patched and a quote and timeline was obtained for new flooring with a plan to install as soon as time allows. The exposed sheetrock was repaired and painted. In room 127 bathroom the sheetrock was repaired and the walls repainted. In the bathroom of room 130 the sink handles were replaced along with the toilet seat cover. An initial inspection will be completed on all other resident rooms by 10/31/17. All needed updates/repairs including gouges, painting and maintenance will be completed by 11/14/17. A monthly audit tool was also created for the maintenance department to inspect all resident rooms on a monthly basis and any needed repairs found will be completed. This will be the responsibility of the maintenance man. A terminal cleaning and repair checklist has been made to incorporate housekeeping with the general upkeep of the resident□s rooms. When a room becomes vacant an extensive general assessment will be made by the housekeeping staff of the rooms status. If any recommendations for renovation or repair are made, the maintenance department will be made aware. The policy and procedure of the maintenance request book will remain the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245510	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE CARE CENTER	649 STATE STREET NORTHWEST EVANSVILLE, MN 56326

(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 465	Continued From page 2 facility practice was for any staff person with knowledge of a maintenance repair need or concern, to put an entry in the Maintenance Request book. The EMD stated he did not conduct routine environmental audits in the facility to identify ongoing environmental needs, and stated he relied on all staff to document environmental issues in the maintenance request book. Review of the Maintenance Request book on 10/05/17, revealed the book did not include documentation with the above concerns. On 10/05/17, at 12:28 p.m. the administrator confirmed the Maintenance Request book was the facility's process to identify environmental concerns, and stated he expected all staff to utilize the book so the repairs could be completed. The undated facility's Maintenance Request policy, indicated the facility would be kept in a clean and safe manner and always in good repair. The policy indicated the maintenance request book was located a the nurse's station, and a requisition was to be completed whenever there was noted item or area that needed repair, replaced or cleaned.	F 465	same. All staff are encouraged to address maintenance repair prior to the monthly maintenance audit. The maintenance and repair will be incorporated in the quarterly safety meeting and will be reviewed at QAA meetings. All staff will be made aware of the updates to current policies through written education. Education will be provided on the importance of providing a safe, clean, functional and homelike environment maintained to the highest standard possible. This will be completed by November 14th, 2017.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 17, 2017

Mr. Brandon Borgstrom, Administrator
Evansville Care Center
649 State Street Northwest
Evansville, MN 56326

Re: State Nursing Home Licensing Orders - Project Number S5510028

Dear Mr. Borgstrom:

The above facility was surveyed on October 2, 2017 through October 5, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson at: (218) 332-5140 or email: gail.anderson@state.mn.us.

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

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

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

Sincerely,

Mark Meath

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

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
	00110	A. BUILDING: _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVANSVILLE CARE CENTER	649 STATE STREET NORTHWEST EVANSVILLE, MN 56326

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 10/2/, 10/3, 10/4 and 10/5/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide appropriate maintenance to ensure a sanitary environment in 4 of 4 resident rooms (#109, #110, #127, #130) reviewed with needed repairs. Findings include: On 10/05/17, from 12:16 p.m. to 12:23 p.m. a tour of the facility was conducted with the environmental maintenance director (EMD). The EMD verified the following resident room concerns: ·Room 109, room walls and closet doors had several areas with gouges, approximately three inches to 10 inches in size, and missing paint in the gouges. ·Room 110, several approximately two inch size gouges in flooring in room and several holes in wall with exposed sheetrock, next to sink. ·Room 127, all four walls in bathroom had multiple gouged areas, approximately 10 inches in length, with exposed sheetrock and missing	21665	21665 Corrected.	11/14/17

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21665	Continued From page 3 paint, multiple holes in bathroom wall near the paper towel holder. ·Room 130, bathroom faucet and handles corroded with a white substance, toilet tank cover cracked, which extended the entire width of the cover. The EMD confirmed the gouges and areas of missing paint identified in the rooms listed above were obvious and needed to be repaired. On 10/05/17, at 12:08 p.m. the EMD confirmed he had not received work orders requesting repairs for the above concerns identified. The EMD reported all staff were expected to notify the maintenance department when repairs were needed by making an entry in the Maintenance Request book located at the nurses station, which he checked daily. The EMD stated the usual facility practice was for any staff person with knowledge of a maintenance repair need or concern, to put an entry in the Maintenance Request book. The EMD stated he did not conduct routine environmental audits in the facility to identify ongoing environmental needs, and stated he relied on all staff to document environmental issues in the maintenance request book. Review of the Maintenance Request book on 10/05/17, revealed the book did not include documentation with the above concerns. On 10/05/17, at 12:28 p.m. the administrator confirmed the Maintenance Request book was the facility's process to identify environmental concerns, and stated he expected all staff to utilize the book so the repairs could be completed.	21665		

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21665	Continued From page 4 The undated facility's Maintenance Request policy, indicated the facility would be kept in a clean and safe manner and always in good repair. The policy indicated the maintenance request book was located a the nurse's station, and a requisition was to be completed whenever there was noted item or area that needed repair, replaced or cleaned. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		

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	245510	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**10/05/2017**

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K 000	INITIAL COMMENTS	K 000		

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 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 YOU 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, Evansville Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
444 CEDAR STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/24/2017

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

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us and Angela.kappenman@ state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Evansville Care Center is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1968 and was determined to be of Type I(332) construction. In 1988, additions were added to the south of the Main Lounge and to the west of the North Wing that were determined to be of Type V(111) construction. In 1998 and addition was added to the end of West Wing that was determined to be of Type V(111) construction. Because the original building and the additions meet the construction types allowed for existing buildings, the facility was surveyed as one building. The facility is completely fire sprinkler protected. The facility has a fire alarm system with smoke detectors in the corridors and areas open to the corridors that is monitored for automatic fire	K 000		

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K 000	Continued From page 2 department notification. The facility has a capacity of 40 beds and had a census of 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=D	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to maintain emergency lighting in accordance with the provisions of the 2012 Life Safety Code, (NFPA 101) section 7.9.2. The deficient practice could negatively affect the ability to exit in the case of a power failure. This could affect and undetermined amount of residents, staff and visitors. Findings include, At 11:00 am on 10/5/17 observations revealed the emergency light in the bottom of the stair shaft did not operate when tested. This deficient condition was confirmed by the Maintenance Supervisor.	K 291	K291 The emergency light at the bottom of the stair shaft will be replaced. This will prevent the inability to exit in case of a power failure as required by the 2012 Life Safety Code. Completion date was 10/16/17. Environmental Services Director is responsible. The Environmental Services Director will conduct a monthly audit and log results to ensure ongoing compliance.	10/16/17
K 324 SS=D	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:	K 324		11/30/17

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K 324	Continued From page 3 * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to install the protection devices of the cooking equipment as stated in the Life Safety Code (NFPA 101) 2012 edition section 9.2.3 & NFPA 96 section 10.5.1. This deficient practice could allow for the spread of fire if staff could not reach the device, affecting an undetermined amount of staff and visitors. Findings include: At 10:15 am on 10/6/17 observations revealed that the pull station for the ANSUL system was not located a minimum of 10 feet from the stove. This deficient condition was confirmed by the Maintenance Supervisor.	K 324	K324 The ANSUL pull station in the kitchen will be moved a minimum of 10 feet from the stove to the other side of the doorway. This will prevent the spread of fire and allow staff to reach the device as required by the 2012 Life Safety Code. Summit Fire Protection was called on 10/6/17, and a service technician came out on 10/9/17 to check areas of concern. A quote will be sent to us and will be completed as Summit□s schedule allows. Environmental Services Director is responsible to contact Summit Fire Protection to have this completed.	

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K 324	Continued From page 4	K 324	Once this is moved there is no risk for reoccurrence and no audit is necessary.	
K 341 SS=F	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (2012) section 19.3.4.1, 9.6.1.3 and NFPA 72 National Fire Alarm Code (2010) section 17.7.4.1. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect all of the 38 residents and an undetermined amount of staff and visitors. Findings include: At 10:17 am on 10/6/17 observations revealed the dining room, which is open to the corridor,	K 341	K341 An additional smoke detector will be installed in the dining room in the section that did not have a detector. This will prevent any delay in the ability of the alarm system to sound in a timely manner during a fire event as required by the 2012 Life Safety Code. Summit Fire Protection was called on 10/6/17, and a service technician came out on 10/9/17 to check areas of concern. A quote will be sent to us and will be completed as Summit□s schedule allows. Environmental Services Director is	11/30/17

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K 341	Continued From page 5 was divided into two sections and did not have a smoke detector on each side. This deficient condition was confirmed by the Maintenance Supervisor.	K 341	responsible to contact Summit Fire Protection to have this completed. Once this is installed there is no risk for reoccurrence and no audit is necessary.	
K 351 SS=D	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to install sprinkler heads in accordance with the 2012 edition of the Life Safety Code (NFPA 101) sections 19.3.5.1, 9.7.1.1 and the 2010 edition of NFPA 13, The Standard for the Installation of Sprinkler Systems. This deficient practice could cause a delay in extinguishing a fire affecting the safety of an undetermined amount of staff and visitors. Findings include:	K 351	K351 A sprinkler system will be installed in the elevator shaft and elevator machine room extended off the current sprinkler system. This will prevent a delay in extinguishing a fire in these two areas as required by the 2012 Life Safety Code. Summit Fire Protection was called on 10/6/17, and a service technician came out on 10/9/17 to check areas of concern. A quote will be sent to us and will be	11/30/17

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	245510	A. BUILDING **01 - MAIN BUILDING 01** B. WING	10/05/2017

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K 351	Continued From page 6 At 10:55 am on 10/6 17 observations revealed the elevator shaft and the elevator machine room was not sprinkler protected. This deficient condition was confirmed by the Maintenance Supervisor.	K 351	completed as Summit□s schedule allows. Environmental Services Director is responsible to contact Summit Fire Protection to have this completed. Once this is installed there is no risk for reoccurrence and no audit is necessary.	
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 The standard for testing and maintenance of sprinkler systems, section 15.5.2. This deficient condition could cause the sprinkler system not to function	K 353	K353 An internal pipe inspection will be completed. This will prevent a deficient condition that could cause the sprinkler system to not function properly and allow for the spread of fire as required by the 2012 Life Safety Code.	11/30/17

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K 353	Continued From page 7 properly and allow for the spread of fire. This could affect all of the 38 residents and an undetermined amount of staff and visitors. Findings include: At 9:02 am on 10/6/17 record review revealed there was no documentation of an internal pipe inspection ever being conducted. At 10:10 am and 10:59 am on 10/6/17 observations revealed the main storage room had materials stacked closer than 18 inches to the sprinkler heads and the lower level furnace room had paint on one of the sprinkler heads. This deficient condition was confirmed by the Maintenance Supervisor.	K 353	Summit Fire Protection was called on 10/6/17, and a service technician came out on 10/9/17 to check areas of concern. A quote will be sent to us and will be completed as Summit□s schedule allows. Environmental Services Director is responsible to contact Summit Fire Protection to have this completed. Once this is installed an inspection will be completed every five years and Summit Fire Protection will provide the report. The inspection date will be tracked by both Summit Fire Protection and Evansville Care Center to ensure compliance. Materials stacked in the main storage area that were closer than 18 inches to sprinkler head will be removed. The shelves will be marked to indicate 18 inches below the sprinkler head to ensure materials are not stacked higher than allowed. This will prevent a deficient condition that could cause the sprinkler system to not function properly and allow for the spread of fire as required by the 2012 Life Safety Code. Completion date will be 11/1/17. The Environmental Services Director and Activities Director will be responsible. The Environmental Services Director will conduct a monthly audit and log results to ensure ongoing compliance.	

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K 353	Continued From page 8	K 353	Sprinkler head that was found to have paint on it in the lower level furnace room will be left as is. As according to Summit Fire Protection, the sprinkler in lower level furnace room has the paint marking to differentiate the temperature in which the sprinkler head will go off. These are installed in maintenance rooms and have a metal file instead of glass to withstand higher temperatures. No further action is required.	
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless	K 363		10/30/17

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K 363	Continued From page 9 the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain two corridor doors in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.6.3.1 & 19.3.6.3.5. This deficient practice could allow for smoke to enter the corridor making it difficult to exit in the case of fire, affecting 7 of the 38 residents and an undetermined amount of staff and visitors. Findings include: At 11:03 am on 10/6/17 observations revealed a small oxygen bottle holding an office door (129) open and at 11:05 observations revealed resident room 133 would bind against the floor when attempted to swing in the full open position. This deficient condition was confirmed by the Maintenance Supervisor.	K 363	K363 The oxygen bottle that was holding the door open in room 129 was removed. This will prevent a deficient practice that could allow for smoke to enter the corridor making it difficult to exit in the case of a fire as required by the 2012 Life Safety Code. Completion date was 10/5/17. The Environmental Services Director is responsible. The Environmental Services Director will educate staff and log attendance regarding the use of doorstops. The Environmental Services Director will conduct a monthly audit and log results to ensure ongoing compliance. The door that binds against the floor and does not swing into full open position will be adjusted to ensure proper operation. This will prevent a deficient practice that could allow for smoke to enter the corridor making it difficult to exit in the case of a	

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K 363	Continued From page 10	K 363	fire as required by the 2012 Life Safety Code. Completion date is 10/30/17. The Environmental Services Director is responsible. The Environmental Services Director will conduct a yearly audit of resident doors and log results to ensure ongoing compliance.	
K 372 SS=F	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain three of three smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of all 38 residents and an undetermined amount of staff and visitors.	K 372	K372 The penetrations of the smoke barriers in the west, east and south wing will be repaired. 3M Fire Caulking was used to seal the cable penetration in the west wing. 3M Fire Caulking and ¿ inch drywall was installed to close the opening in the east wing. 3M Fire Caulking was used to seal the 1-inch x 10 inch opening	10/12/17

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K 372	Continued From page 11 Findings include: On 10/6/17 observations revealed penetrations of smoke barriers in the following locations. 1. At 9:41 am a cable penetration above the cross corridor doors in the west wing. 2. At 9:56 am an opening along the wall above the cross corridor doors in the east wing 3. At 10:02 am a 1 inch x 10 inch opening above the cross corridor doors in the south wing This deficient condition was confirmed by the Maintenance Supervisor.	K 372	in the south wing. This will prevent a deficient practice that could allow the smoke to transfer from one smoke compartment to another as required in the 2012 Life Safety Code. Completion date was 10/12/17. The Environmental Services Director is responsible. Once these are repaired, there is no risk for reoccurrence. If installation of wires, plumbing, heating or cooling is done, the Environmental Services Director will ensure all penetrations are sealed upon completion of project.	
K 521 SS=B	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain proper exhaust throughout the east resident wing as required by the 2012 Life Safety Code (NFPA 101) section 9.2.2 and NFPA 91 Standard for Exhaust Systems for Air Conveying of Vapors, Gases, Mists and Noncombustible Particulate Solids. This deficient practice could negatively affect 7 of	K 521	K521 The bathroom fans in resident rooms in the east wing that are not operable will be replaced. This includes rooms 126 and 119. This will maintain proper exhaust throughout the east wing as required by the 2012 Life Safety Code. Bathroom fans were ordered on 10/23/17	11/30/17

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K 521	Continued From page 12 the 38 residents and an undetermined amount of staff and visitors. Findings include: At 10:37 am on 10/6/17 observations revealed the bathroom fans in the resident rooms in the east wing were not operable. This deficient condition was confirmed by the Maintenance Supervisor.	K 521	with a target arrival date of 11/20/17 and will be installed when they arrive. The Environmental Services Director is responsible. The Environmental Services Director will conduct a monthly audit and log results to ensure ongoing compliance.	