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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: BVCN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00626

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245418**

2.STATE VENDOR OR MEDICAID NO.
(L2) **901743700**

3. NAME AND ADDRESS OF FACILITY
(L3) **BELGRADE NURSING HOME**
(L4) **103 SCHOOL STREET, PO BOX 340**
(L5) **BELGRADE, MN** (L6) **56312**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/13/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **54** (L18)

13.Total Certified Beds **54** (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
	54			
(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 :
Teresa Ament, Unit Supervisor — 09/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 10/07/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(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) **00**

VOLUNTARY
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 11/18/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/23/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245418
October 7, 2016

Ms. Stephanie Fischer, Administrator
Belgrade Nursing Home
103 School Street, Po Box 340
Belgrade, MN 56312-0340

Dear Ms. Fischer:

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 September 13, 2016 the above facility is certified for or recommended for:

54 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 30, 2016

Ms. Stephanie Fischer, Administrator
Belgrade Nursing Home
103 School Street, Po Box 340
Belgrade, MN 56312-0340

RE: Project Number S5418026

Dear Ms. Fischer:

On August 24, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 11, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 16, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 11, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 13, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 11, 2016, effective September 13, 2016 and therefore remedies outlined in our letter to you dated August 24, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245418 Y1	A. Building B. Wing Y2	9/16/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0164	Correction	ID Prefix F0257	Correction	ID Prefix F0334	Correction
Reg. # 483.10(e), 483.75(l)(4)	Completed	Reg. # 483.15(h)(6)	Completed	Reg. # 483.25(n)	Completed
LSC	09/06/2016	LSC	09/14/2016	LSC	09/13/2016
ID Prefix F0441	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/14/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	BF/kfd	9/30/2016	13922	9/16/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/11/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: BVCN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00626

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(L1) **245418**

2.STATE VENDOR OR MEDICAID NO.
(L2) **901743700**

3. NAME AND ADDRESS OF FACILITY
(L3) **BELGRADE NURSING HOME**
(L4) **103 SCHOOL STREET, PO BOX 340**
(L5) **BELGRADE, MN** (L6) **56312**

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 **08/11/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **54** (L18)

13.Total Certified Beds **54** (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
	54			
(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 :
Pam Kerssen, Assistant Program Manager 09/06/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 09/22/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(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 09/23/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 24, 2016

Ms. Stephanie Fischer, Administrator
Belgrade Nursing Home
103 School Street, PO Box 340
Belgrade, Minnesota 56312-0340

RE: Project Number S5418026, H5418012

Dear Ms. Fischer:

On August 11, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the August 11, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5418012. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the August 11, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5418012 that was found to be unsubstantiated.

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

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

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

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

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

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:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Brenda.fischer@state.mn.us
Phone: (320) 223-7338
Fax: (320) 223-7348

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 September 20, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 November 11, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on

the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 11, 2017 (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 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
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 / eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	**103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312**

(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 8/8/16, to 8/11/16, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Belgrade Nursing Home was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. An investigation of complaint H5418012 was completed at the time of the recertification survey. The complaint was unsubstantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 164		9/6/16

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

Electronically Signed | 08/31/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	103 SCHOOL STREET, PO BOX 340 BELGRADE, MN 56312

(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 164	Continued From page 1 Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure permission was acquired for the use of a video monitoring system for 1 of 6 residents (R59), and ensure the video feed from the monitoring device was maintained in a private location which was not readily visible to the public. This had potential to affect 6 of 6 residents (R21, R40, R6, R59, R56, and R23) who had video monitoring devices present in their room(s). Findings include: R6, R21, R23, R40, R56, and R59 were identified by the facility to have the need for increased visual monitoring by implementing the use of video monitors within the room. R6's quarterly Minimum Data Set (MDS) dated	F 164	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The video monitoring system was removed from Nurses Station and resident rooms. Address how the facility will identify other resident having the potential to be affected by the same deficient practice: No other residents will be affected due to the removal of the video monitoring system. Address what measures will be put into place or systemic changes made to	

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	245418	A. BUILDING _____ B. WING _____	08/11/2016

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F 164	Continued From page 2 6/16/16, indicated that R6 was severely cognitively impaired and had diagnoses which included dementia and depression. R21's 14 day MDS dated 7/27/16, identified that R21 had severely impaired cognition. R23's quarterly MDS of 5/26/16, identified that resident had moderately impaired cognition and had diagnoses which included dementia. R40's 14 day MDS dated 7/21/16, identified R40 had severely impaired cognition. R56's admission MDS of 7/21/16, identified that R56 had severe cognitive impairment. R59 was a recent admit and had not yet had a MDS completed. On 8/8/16, at 8:59 a.m., during the initial facility tour it was noted there were four resident rooms with video monitors in place. The units were noted to be approximately two inches by two inches on the base, with a camera and antenna positioned within the unit, measuring approximately four inches in height. The units were noted to be positioned on nightstands and directed toward the resident's bed. The screen for viewing the video monitors was observed positioned at the nurse's station in the main lobby area. The screen measured approximately five by five inches and was noted to be on the left side of the computer monitor on the lower portion of the desk in the main lobby. The desk was shaped in a modified L fashion with an upper level for those standing by the desk and a lower tier on which the computer monitor and video screen were positioned. This screen was noted to be easily	F 164	ensure that the deficient practice will not recur: The video monitoring system was removed. Policies and Procedures modified to reflect these changes. Nursing Staff will be informed of this change. Indicate how the facility plans to monitor its performance to make sure that solutions are meeting its effectiveness. The plan of correction is integrated into the quality assurance system: The video monitoring system was removed.	

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observed by any individual standing on the north or west side of the desk.

On 8/9/16, at 6:05 p.m. the video screen was easily viewed while standing on the north side of nurse's station. The video screen was rotating through rooms, with one screen noted to be blank, displaying "No signal" during that rotation.

On 8/9/16, at 6:39 p.m. R21 was observed on the video screen receiving assistance to lay on the bed.

On 8/9/16, at 6:41 p.m. R56 was observed on the video screen receiving assistance to lay on the bed. The video screen was noted to be scrolling through video feed with three rooms displayed.

On 8/10/16, at 3:19 p.m. the video screen was observed to be rotating between three rooms. R21 was noted to be seated in their room. R23 was not in the room at this time, and the camera did not display roommate, R59.

On 8/10/16, at 3:24 p.m. R21's door to the room was noted to be closed. The video screen was viewed from the north side of the desk and was noted to scroll through three rooms being monitored and one screen stated "no signal." The view on the video screen displayed the resident sitting by the bed in a wheelchair.

On 8/10/16, at 5:14 p.m., the video screen was noted to remain on the left corner of the desk at the nurse's station and was easily viewed from the west side of the nurse's desk. The video screen was noted to be rotating between three rooms, and one screen displayed "no signal."

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On 8/11/16, at 6:55 a.m. the camera remained positioned on the left side of the desk and was scrolling through three rooms. The monitor displayed R56 moving about in the room. The video screen displayed empty beds/rooms for two views. The final screen indicated "no signal."

On 8/11/16, at 7:48 a.m. R21 was observed sleeping in bed, while scans 2 and 4 were noted to display empty rooms. The final screen displayed "no signal."

During interview on 8/11/16, at 11:09 a.m. nursing assistant (NA)-B stated the video monitors were viewed only, not recorded. NA-B stated the monitors were left on at all times. NA-B stated personal cares were typically performed in the bathroom so they were not generally viewed by the monitor. NA-B stated the monitors remained on at all times and the video screen was routinely positioned on the desk to the left side of the computer.

During interview on 8/11/16, at 11:43 a.m. registered nurse (RN)-B stated that video monitors were used for residents who had a history of falls and may not consistently remember to call for assistance prior to getting up. RN-B stated the video monitor allowed them to see if the residents were getting restless or trying to get up independently and allowed staff to go to the room and offer assistance. RN-B stated the camera was a screen shot only and did not record data. Residents were assessed by the facility for the need for a video camera, additionally, families may also request the use of video monitoring. RN-B stated consents for video monitors were completed with residents and or the responsible party/legally appointed individual

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prior to implementation of the video monitor.
RN-B stated a consent was also completed with the roommate. RN-B admitted a consent had not yet been completed with R59, who had recently admitted into the same room with R23. RN-B stated the consent for use of a video monitor for a new admit would generally be completed at the time of admission into a room where a monitor was being used. A visual observation of the video screen was completed with RN-B who acknowledged the video screen could be viewed by individuals standing at the north and east end of the desk. RN-B stated "Yes, you can see it" while standing on the north and west sides of the desk. RN-B stated that "it is a concern regarding privacy."

On 8/11/16, at 12:17 p.m. social service (SS)-A stated the use of video monitors was reviewed with residents/family members/and responsible parties prior to implementation.

On 8/11/16, at 12:30 p.m. the administrator (A) stated that the video screen used to monitor the residents status was to be kept behind the computer to maintain privacy.
A facility policy dated 2/11/16, Video Monitors, identified the facility "occasionally uses video monitors in hallways, outside areas, in resident rooms, etc., to monitor the safety and well-being of our staff and residents. The facility will use any video monitors in accordance with applicable laws and regulations." The policy did not identify specific placement of the video screen to monitor residents. The procedure outlined in this policy, indicated "Residents are informed of the facility's use of video monitors throughout the building. Consent forms are obtained allowing the facility to use the video monitor for the particular resident

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F 164	Continued From page 6 and roommate, if applicable."	F 164		
F 257 SS=C	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comfortable temperature was maintained in the dining room for 1 of 1 residents (R10) who voiced concerns the room was too cold. This had potential to affect 40 of 40 residents who use the space for eating or activities. Findings include: R10's quarterly minimum data set (MDS), dated 5/31/16, indicated she was cognitively intact and had no neurological disorders. On 8/9/16, at 1:32 p.m., R10 stated the dining room was too cold and was told by staff it could be a little warmer. Additionally, R10 was told by staff that she could eat in a different room or outside if it was too cold. An environmental tour was done with the plant operations manager (POM) on 8/10/16, at 3:11 p.m.. During the tour, the POM read the thermometer on the wall in the dining room temperature and reported the temperature was 69 degrees Fahrenheit. The POM stated it was	F 257	The temperature in the Dining Room was adjusted to meet the standard the day it was found to be too cold. A lock box was put over the thermostat to prevent staff from adjusting the temperature without monitoring the effects. A thermometer was put in the Dining Room to help monitor the temperature due to the fact that the thermostat is in another location. A Temperature Level policy and procedure written to reflect temperature standards and to aide staff member in addressing out of range temperatures or concerns regarding temperatures in resident areas. Additional thermometers have been placed throughout the building to help with monitoring temperatures.	9/14/16

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F 257	Continued From page 7 too cold. The POM stated the facility had one main air conditioning unit that controlled the whole building; however, cool air blown into the dining room was controlled via a thermostat located in the dietary offices. Upon further inspection, staff had turned down the thermostat to increase the air conditioning. According to the POM, the wall thermostat located in the dining room, controlled the heat, which was on a different system. It could not be adjusted during the summer. In addition, the plant operations manager reported if residents were concerned about the temperature, the nursing staff would notify him via the radio. He had been notified recently of a complaint, and he adjusted one of four vents in the dining room to decrease its coolness. He also stated residents who were too cold could eat in a separate activities room located at the other end of the hall. The POM stated the goal was to regulate the facility at 73 to 74 degrees Fahrenheit. In an effort to regulate the building, he checked temperatures in the common areas daily; however, he reported he did not keep logs of the temperature checks. Additionally, he did not have a specific facility policy related to temperatures but went by the federal regulations. A facility policy entitled: Quality of Life- Homelike Environment, last revised 8/11, directed staff and management to maximize a "personalized, homelike setting," which included comfortable temperatures. The policy did not elaborate on the facility's process to ensure comfortable temperature were maintain.	F 257	A building temperature log was developed and requires different areas of the building to be monitored at alternating times of the day. The policy and procedure will be reviewed at the Department Head Meeting. The Plant Operations Manager will review the log weekly to identify trends. The Plant Operations Manager will also bring the findings to the quarterly Quality Assurance Meeting.	
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	F 334		9/13/16

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F 334	Continued From page 8 The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 334		

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F 334	Continued From page 9 (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the pneumococcal conjugate vaccine (PCV13) for 4 of 5 residents (R34, R33, R23, R22) whose vaccination histories were reviewed. Findings include: The Center for Disease Control and Prevention (CDC) recommended, "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more	F 334	R22 received PCV13 on 8/30/16. R34 and R23 consented to receive the vaccination and has been ordered, will be administered upon receipt of the vaccination. R33 awaiting consent from POA and will order and administer upon POA consent. RN conducted a house wide pneumococcal vaccination audit.	

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F 334	Continued From page 10 doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of PCV13. The dose of PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose." R34's Immunization Report, undated, indicated the 74 year old resident had received a Pneumovax outside the facility on 12/7/06. However, the facility did not offer the PCV13 according to the CDC guidelines. R33's Immunization Report, undated, indicated the 90 year old resident had received a Pneumovax outside the facility on 1/17/12. However, the facility did not offer the PCV13 according to the CDC guidelines. R23's Immunization Report, undated, indicated the 88 year old resident had received a Pneumovax outside the facility on 3/24/14. However, the facility did not offer the PCV13 according to the CDC guidelines. R22's Immunization Report, undated, indicated the 79 year old resident had received a Pneumovax outside the facility on 3/29/05. However, the facility did not offer the PCV13 according to the CDC guidelines. On 8/9/16, at 5:15 p.m. registered nurse (RN)-D stated the facility was currently not offering the PCV13, and denied knowledge of the CDC guidelines. On 8/9/16, at 6:51 p.m. the director of nursing (DON) stated there had been no discussions at the facility about the PCV13 or CDC guidelines, and denied knowledge of the CDC guidelines.	F 334	Residents found to be eligible for the vaccination will be provided an informational sheet and consent obtained. Upon receipt of the consent, vaccination will be administered. The Pneumococcal Vaccination policy and procedure has been updated to follow the CDC's Pneumococcal guidelines. Nursing Home Standing Orders have been updated by the Medical Director to follow the CDC's aged based Pneumococcal guidelines. Nursing Staff will be educated on the changes to the Pneumococcal Vaccination policy and procedure. A monthly pneumococcal vaccination report will be reviewed by the Director of Nursing or designee to ensure compliance. The Quality Assurance Team will review the finding.	

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F 334	Continued From page 11 The facility policy with a revision date of 2/22/16, Pneumovax Vaccine, identified all new admissions will be screened and given the Pneumovax vaccine unless specifically ordered otherwise on admission orders by the primary physician.	F 334		
F 441 SS=B	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		9/14/16

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F 441	Continued From page 12 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure personal grooming supplies were not shared in order to reduce the risk of potential cross contamination between residents. This had the potential to affect 8 of 8 residents (R33, R36, R21, R26, R48, R2, R31, R17) identified as using the same deodorant stick. Findings include: R33 was observed for personal cares on 8/11/16, at 8:00 a.m.. Nursing assistant (NA)-B applied lotion to his skin after drying him off following his bath. NA-B applied a blue gel-stick deodorant to R33. As NA-B exited the tub room with R33, a variety of sprays were noted on the table where the deodorant was placed. NA-B stated the deodorant was used by the male residents who do not have a personal supply of deodorant. NA-B stated there was a spray deodorant for the female residents who do not have their own supply of deodorant. On 8/11/16, at 12:42 p.m. NA-B stated shared deodorant for residents has been in place for "years." NA-B stated nursing assistants apply roll-on deodorants or sprays, "whatever is in there". NA-B stated there were currently eight	F 441	The roll on deodorant was immediately removed from the Tub Room to ensure there is no further cross contamination for R33, R36, R21, R26, R48, R2, R31, and R17. Director of Nurses conducted an audit on the use of stock personal hygiene products. Audit produced no additional residents affected by deficient practice. All stock personal hygiene products have been removed from facility and will no longer be purchased by facility. Resident purchased products will be labeled to ensure their use only. Nursing staff will be reeducated on the use of nursing home stock products with an emphasis on the risk of potential cross contamination.	

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F 441	Continued From page 13 residents (R33, R36, R21, R26, R48, R2, R31, and R17) who received application of the shared facility stock gel deodorant after bathing. NA-B stated "we should just have all sprays." NA- B added it was "gross." NA-B stated "I hope nobody puts it on anyone with sores, but there is potential" for this to happen. On 8/11/16, at 1:05 p.m. registered nurse (RN)-B stated the deodorant in the tub room was for residents "that don't have their deodorant with them." RN-B stated most residents bring their own deodorant with them. RN-B stated that the "biggest concern would be infection control." RN-B further stated "spray deodorant is optimal." A policy was requested to address infection control practices with use of community resources but was not provided.	F 441	The Director of Nursing or designee will monitor the use stock products weekly and conduct biweekly audits of staff stock use practices. The finding will be reviewed at the quarterly Quality Assurance Meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/08/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	**103 SCHOOL STREET. PO BOX 340 BELGRADE, MN 56312**

(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	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 08, 2016. At the time of this survey, Building 01 of Belgrade Nursing Home was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies Building 01 of Belgrade Nursing Home was constructed as follows: The original building was constructed in 1965, is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction; The 1968 addition is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction; The 1981 addition is one story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction; The 1987 addition is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction; The 1988 addition is one story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type V(111) construction. The 1988 building addition consists of seven (7) senior apartments. Because the 1988 addition was not separated from the nursing home by 2-hour construction, the senior apartments were	K 000		

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

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/08/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	**103 SCHOOL STREET. PO BOX 340 BELGRADE, MN 56312**

(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 1 surveyed as part of the nursing home. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which are monitored for automatic fire department notification. The facility has a licensed capacity of 49 beds and had a census of 41 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245418	A. BUILDING **02 - PT-E THERPY** B. WING _____	**08/08/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELGRADE NURSING HOME	**103 SCHOOL STREET. PO BOX 340 BELGRADE, MN 56312**

(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	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 08, 2016. At the time of this survey, Building 02 of Belgrade Nursing Home was found to be 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 Occupancies Building 02 of Belgrade Nursing Home consists of the 2013 Physical Therapy addition. This addition is one-story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type V(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which are monitored for automatic fire department notification. The facility has a licensed capacity of 49 beds and had a census of 41 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

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.