

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: EE46

Facility ID: 00800

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

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

DETERMINATION APPROVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245401

September 20, 2018

Administrator
Central Health Care
444 North Cordova
Le Center, MN 56057

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 24, 2018 the above facility is certified 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,

A handwritten signature in black ink, appearing to read 'Douglas Larson'.

Douglas Larson, Enforcement Specialist

Central Health Care

September 20, 2018

Page 2

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 20, 2018

Administrator
Central Health Care
444 North Cordova
Le Center, MN 56057

RE: Project Number S5401027

Dear Administrator:

On August 15, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 2, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 19, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 11, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 2, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 24, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 2, 2018, effective August 24, 2018 and therefore remedies outlined in our letter to you dated August 15, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Douglas Larson'.

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EE46

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00800

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245401	3. NAME AND ADDRESS OF FACILITY (L3) CENTRAL HEALTH CARE (L4) 444 NORTH CORDOVA (L5) LE CENTER, MN (L6) 56057	4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint
2. STATE VENDOR OR MEDICAID NO. (L2) 936540100	7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	6. DATE OF SURVEY 08/02/2018 (L34)	8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other
11. LTC PERIOD OF CERTIFICATION From (a): To (b):	10. THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements Compliance Based On: ___ 1. Acceptable POC ___ 2. Technical Personnel ___ 6. Scope of Services Limit ___ 3. 24 Hour RN ___ 7. Medical Director ___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size ___ 5. Life Safety Code ___ 9. Beds/Room X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)	
12. Total Facility Beds 40 (L18)	13. Total Certified Beds 40 (L17)	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 :

Dawn Chiabotti, HFE II

08/28/2018

(L19)

18. STATE SURVEY AGENCY APPROVAL

Date:

Kamala Fiske-Downing, Sr. Health Program Rep 09/14/2018

(L20)

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

19. DETERMINATION OF ELIGIBILITY ___ 1. Facility is Eligible to Participate ___ 2. Facility is not Eligible (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 12/01/1986 (L24)	23. LTC AGREEMENT BEGINNING DATE (L41)	24. LTC AGREEMENT ENDING DATE (L25)
25. LTC EXTENSION DATE: (L27)	27. ALTERNATIVE SANCTIONS A. Suspension of Admissions: (L44) B. Rescind Suspension Date: (L45)	
26. TERMINATION ACTION: (L30) <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 15, 2018

Mr. Karl Pelovsky, Administrator
Central Health Care
444 North Cordova
Le Center, MN 56057

RE: Project Number S5401027

Dear Mr. Pelovsky:

On August 2, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 11, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 11, 2018 the following remedy will be imposed:

- 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 November 2, 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 February 2, 2019 (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

Central Health Care
August 15, 2018
Page 6

St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Douglas Larson", with a long horizontal flourish extending to the right.

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

PRINTED: 08/28/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2018
NAME OF PROVIDER OR SUPPLIER CENTRAL HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 444 NORTH CORDOVA LE CENTER, MN 56057		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 000	Initial Comments	E 000			
E 041	A survey with CMS Appendix Z Emergency Preparedness Requirements was conducted on 7/30/18 to 8/2/18, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements. Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The	E 041		8/24/18	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/24/2018

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

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

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NAME OF PROVIDER OR SUPPLIER CENTRAL HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 444 NORTH CORDOVA LE CENTER, MN 56057		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 041	Continued From page 1 [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000.	E 041			

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
E 041	Continued From page 2 (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the emergency generator inspection and testing was implemented in accordance with the requirements. This had the potential to affect all 27 residents residing in the facility. Findings include: During an inspection of the facility on 7/31/18, between the hours of 10:00 a.m. and 1:00 p.m. the Fire Marshal with the facility Maintenance Supervisor (MS) revealed there was no documentation to show that annual maintenance had occurred on the emergency generator.	E 041	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. Submission of this plan of correction is not an admission that the deficiency existed or that it is cited accurately. This plan of correction is submitted to meet state and federal requirements. E401 ☐ Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) It is the policy of Central Health Care to test and maintain Essential Electric Systems (emergency generator) in accordance with 6.4.4, 6.5.4, 6.6.4 (NFPA		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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E 041	Continued From page 3 On 08/02/18, at 8:37 a.m. MS stated he ran the generator for 30 minutes monthly and inspected the generator weekly. MS stated he was unaware of any need to have the generator tested yearly by an outside vendor and could not produce any documentation for this.	E 041	99), NFPA 110, NFPA 111, 700.10 (NFPA 70). It is also the policy of Central Health Care to maintain written records of maintenance/testing related to Essential Electric Systems and ensure those records are readily available. Central Health Care had Generator System Services Inc. conduct an annual generator maintenance, inspection and testing on 08/23/2018. To ensure ongoing compliance with testing and maintaining Essential Electric Systems (emergency generator), Central Health Care has developed a calendar tracking system which is monitored and maintained by the Maintenance Director or designee. The Safety Committee will monitor and review monthly to ensure required inspections and testing is completed in a timely manner. The Maintenance Director has been re-educated on the testing/inspection frequency required with 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70). The Maintenance Director or designee will monitor monthly required inspections, maintenance, and testing to prevent a reoccurrence of this deficiency to ensure continued compliance is maintained. Compliance Date: 08/31/2018		
F 000	INITIAL COMMENTS On 7/30/18 to 8/2/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility	F 000			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 000	Continued From page 4 was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC 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 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an assessment for safe medication administration was completed for 1 of 1 residents (R10) reviewed. Findings include: On 8/1/18, at 7:07 a.m. R10 was observed sitting in his room holding three pills of medication in his left hand and nine pills of medication in a little cup setting on his dresser, along side a little cup of applesauce and small glass of water. R10 then lifted his left hand up to his mouth inserted the pills, took a sip of water and swallowed the	F 554	F 554 Self-Administration of Medications It is the policy of Central Health care that any resident who is deemed competent and wishes to self-administer their medications retain the right to do so. A new self-administration review was done on 8.12.18 and resident #10 stated that he did not wishes to self-administer his medications. Resident #10 continues to require supervision to take his medications. Other residents were audited to ensure compliance with		8/24/18

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

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F 554	Continued From page 5 medications. R10 stated he had taken some medications earlier also. At the time of this observation the licensed practical nurse (LPN)-A was standing at her medication cart with her back to the resident room looking at the computer screen and was punching out medications from cards. LPN-A was not watching R10 administer his own medications and was observed leaving her medication cart to assist other residents. At 7:36 a.m. no cups were observed on R10's dresser and R10 was in the bathroom. On 8/1/18, at 9:26 a.m. LPN-A stated R10 had not been assessed whether he could safely administer his own medications. LPN-A stated R10 had wanted his medications today early, and stated, "I was right here in the hall around the cart." LPN-A stated she had brought R10's medications in a cup and put on his dresser but had not watched R10 take them. LPN-A explained she went back and checked on R10 to make sure he had taken them. LPN-A stated she should have kept her eye on him when he was taking his medications. On 8/2/18, at 1:19 p.m. the director of nursing (DON) stated nurses should have the residents in sight when residents were taking their medications and residents should be assessed if they were administer their own medications. DON verified R10 had not been assessed to safely administer his own medications nor was there a physician order for R10 to administer his own medications. R10's SAM (Self Administration Medication) assessment dated 5/20/18, indicated R10 did not want to administer his own medications. The 5/20/18, SAM assessment indicated R10 had not	F 554	self-administration of medications. No other residents were affected. Education was provided to the nurse at the time of notification of concern. Nurses will be retrained on Process of Self-Administration rights and need for Physicians orders to perform task. Nurses/TMA□S will also be retrained on Proper Medication administration rights including supervising residents when administering medications unless they have been deemed competent to perform and have current physicians order to self-administer. DON or designee will conduct medication pass audits weekly times 4 than monthly thereafter to ensure continued compliance. Audit results will be tracked and shred with Quarterly QA by the DON or designee. Compliance Date: 9.7.18		

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F 554	Continued From page 6 been assessed to safely administer his own medications. Review of R10's current physician orders dated 7/2/18 through 8/2/18, indicated R10 did not have an order to administer his own medications. The facility's Self-Administrations Of Medications policy dated April 2014, indicated residents could self-administer medications if the interdisciplinary team had determine it would be safe for the resident and nursing had obtained a signed order from the physician.	F 554			
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623		8/24/18	

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F 623	Continued From page 7 resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and	F 623			

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F 623	Continued From page 8 telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 resident (R26) or legal representative were provided a written notice of transfer to a hospital. In addition, the facility failed to send notice of a facility initiated transfer and/or discharge to the long term care	F 623	F 623 Notice requirements before transfer/discharge It is the policy of Central Health Care to inform all residents/responsible parties of their right to hold their bed when they are		

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F 623	Continued From page 9 ombudsman for 1 of 2 residents (R26) reviewed for hospitalization. Findings include: Review of R26's progress note (PN) dated 5/20/18, at 7:45 p.m. indicated R26 had a mildly displaced sub capital right femoral neck fracture and the nurse practitioner recommended R26 to be transferred to the hospital. Review of R26's PN dated 5/20/18, at 8:03 p.m. indicated R26 was sent to the hospital via emergency medical services. R26's electronic medical record (EMR) revealed there was no discharge summary or documentation of written notification of transfer provided to R26, her representative or the ombudsman. On 8/1/18, at 11:00 a.m. the director of nursing (DON) stated the facility had not always been providing written notification of transfer to residents, their representatives or the ombudsman. The DON also stated the facility had not been sending all resident hospital transfer notices to the ombudsman but should be and will do it in the future. On 8/1/18, at 1:24 p.m. the DON stated she was responsible for discharge notifications and the facility had not notified R26, her representative or the ombudsman in writing of her transfer to the hospital. A facility policy regarding transfer notifications was requested and not provided.	F 623	transferred from the facility. Resident/responsible party is provided a copy of the bed hold form upon admission to the facility. When a resident is transferred from the facility the family/resident is given the choice to hold the bed or not. A verbal confirmation is received unless the family/resident is in the facility and the form is signed at the time of transfer. Resident #26 had an Emergency Transfer to the hospital, the family had given verbal approval to hold the bed, the form was completed incorrect and chart lacked documentation. Notification to the Ombudsman was not completed in a timely manner i.e., monthly Bed Hold Policy and Procedure was updated to reflect new notification process. A copy of the bed hold will be sent with the resident attached to the Transfer form indicating the reason for transfer from facility. Bed Holds will be obtained, put into electronic chart and then mailed to the family with each occurrence. Policy and Procedure regarding notification to the Ombudsman was updated to reflect the requirement of F623. Social Worker will fax the notification with each transfer and upload in resident's electronic record monthly. Resident chart audits were completed and resident no other residents were affected.		

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F 623	Continued From page 10	F 623	The Social Worker did update the Ombudsman of all transfers on 8.20.18 and will perform monthly. Social Worker and nursing staff re-educated on the proper procedure. Audits will be completed by the Social Worker or designee with each transfer, at IDT meetings, weekly and quarterly with results to the QAA for review. Compliance Date: 9.7.18		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for	F 625		8/24/18	

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F 625	Continued From page 11 hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure bed hold notification was provided for 1 of 2 residents (R26) reviewed for hospitalization. Findings include: Review of R26's progress note (PN) dated 5/20/18, at 7:45 p.m. indicated R26 had a mildly displaced sub capital right femoral neck fracture and the nurse practitioner recommended R26 to be transferred to the hospital. Review of R26's PN dated 5/20/18, at 8:03 p.m. indicated R26 was sent to the hospital via emergency medical services. R26's electronic medical record (EMR) revealed there was no documentation of R26 or her representative being provided bed hold information when she was transferred to the hospital on 5/20/18. On 8/1/18, at 11:00 a.m. the director of nursing (DON) stated the facility had not documented or had proof they provided bed hold information to R26 or her representative when she transferred to the hospital on 5/20/18, and they should have. DON further stated there was a bed hold form in R26's EMR but it did not have any information filled out on it.	F 625	F 625 BED HOLD It is the policy of Central Health Care to inform all residents/responsible parties of their right to hold their bed when they are transferred from the facility. Resident/responsible party is provided a copy of the bed hold form upon admission to the facility. When a resident is transferred from the facility the family/resident is given the choice to hold the bed or not. A verbal confirmation is received unless the family/resident is in the facility and the form is signed at the time of transfer. Resident #26 had an Emergency Transfer to the hospital, the family had given verbal approval to hold the bed, the form was completed incorrect and chart lacked documentation. Notification to the Ombudsman was not completed in a timely manner i.e., monthly Bed Hold Policy and Procedure was updated to reflect new notification process. A copy of the bed hold will be sent with the resident attached to the Transfer form indicating the reason for transfer from facility. Bed Holds will be obtained, put into electronic chart and		

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F 625	Continued From page 12 On 8/1/18, at 1:24 p.m. the DON stated facility staff should provide bed hold information to residents and/or their representatives upon transfer to a hospital and document it in the EMR and that had not been done properly for R26's discharge to the hospital on 5/20/18. DON also stated she had initiated training for staff regarding proper discharge procedures. A facility bed hold policy and procedure was requested and not provided.	F 625	then mailed to the family with each occurrence. Policy and Procedure regarding notification to the Ombudsman was updated to reflect the requirement of F623. Social Worker will fax the notification with each transfer and upload in resident's electronic record monthly. Resident chart audits were completed and resident no other residents were affected. The Social Worker did update the Ombudsman of all transfers on 8.20.18 and will perform monthly. Social Worker and nursing staff re-educated on the proper procedure. Audits will be completed by the Social Worker or designee with each transfer, at IDT meetings, weekly and quarterly with results to the QAA for review. Compliance Date: 9.7.18		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a change in resident code status was reflected on the physician orders and communicated to staff for 1 of 1 residents (R6) reviewed for Advance Directives.	F 678	F 678 - POLST Form It is the policy of Central Health care to ensure that each resident has a signed Physician Provider Orders for	8/24/18	

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F 678	Continued From page 13 Findings include: R6's POLST (Provider Orders for Life-Sustaining Treatment) dated and signed by family representative and certified nurse practitioner (CNP) on 7/26/17, indicated R6 wanted "Attempt Resuscitation/ CPR" and "Full Treatment/Use Intubation". R6's 5/19/18 through 7/18/18, current physician orders signed and dated by CNP on 7/18/18, indicated an order for code status "DNI [Do Not Intubate]/No TUBE FEEDING" started on 6/9/16. R6's face sheet printed out 8/1/18, indicated "Full Code, DNI". On 8/1/18, at 1:42 p.m. licensed practical nurse (LPN)-B stated if a resident coded she would follow the code status listed on the e-mar (electronic medication administration record) for that resident. LPN-B verified R6's e-mar indicated R6 code status was Full Code and DNI. LPN-B stated the code status on the e-mar came from R6's face sheet. LPN-B stated if R6 coded she would look at R6's code status on the e-mar, follow that and go help R6. LPN-B stated she would not look at R6's POLST because it was "all on the e-mar". LPN-B stated she would make sure R6 was not intubated as that had happened once at the hospital when R6's family representative could not be contacted. LPN-B verified R6's POLST dated 7/27/17, did not match R6's e-mar, nor R6's face sheet, nor R6's current physician orders. LPN-B stated she had been not aware the different documents did not match and stated R6's POLST needed to be reviewed and updated.	F 678	Life-Sustaining Treatment (POLST) form in their medical record which reflects their treatment choices/preferences. Each residents record has been audited and has only affected this resident. Resident #6 and her Responsible Party attended a care conference on 8.9.18 and her POLST status was reviewed. Resident expressed her desire to remain at Full Code with No intubation. A new POLST form was signed by all parties Physicians orders were changed to reflect this status. Nurses and Social Worker will be re-educated on 09/05/2018 of Facilities Advance Directives Policy and Procedure and location of information on Code Status. Residents POLST status, Face Sheet and Physicians Orders will be reviewed at quarterly Care conference to ensure all areas match. MN POLST form will be updated with revision of 2017. Audits by Social Worker/DON or designee of Advance Directives will be reviewed on admission, quarterly care conferences and with any resident status changes and shared with the IDT team and Quarterly QAA. Compliance Date: 9.7.18		

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F 678	Continued From page 14 On 8/1/18, at 2:08 p.m. director of nursing (DON) stated POLST were updated upon admission, after hospitalizations, at care conferences, and was the social worker's responsibility. DON stated staff was expected to follow the resident's POLST. DON stated R6's orders had not been updated after the code status had been changed as indicated on the POLST dated 7/27/17. DON verified R6's POLST dated 7/27/17, did not match the current physician orders stating the current physician order for code status had been started 6/9/16, and had not been changed and needed to be updated. DON stated she would talk with R6's mother to clarify R6's code status. The facility's undated ADVANCE DIRECTIVE POLICY AND PROCEDURE indicated changes to the resident choices for advance directives would be communicated to staff providing resident care and physician orders would be obtained to reflect the resident's new choices.	F 678			
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by:	F 740			8/24/18

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F 740	Continued From page 15 Based on observation, interview and document review, the facility failed to identify, comprehensively assess, develop and implement individualized person centered behavior interventions to address psychosocial needs of 1 of 4 residents (R7) reviewed who stuck pieces of tissue and paper towels into his mouth between his lower lip and gums. Findings include: R7's diagnosis identified by the nurse practitioner (NP)-A on the summary encounter dated 7/16/18, included dementia with behavior disturbance, hallucinations, and unspecified psychosis. A cognition note from the Care Plan Conference Summary dated 2/27/18, indicated R7 had severe cognition impairment due to dementia. . During an observation on 7/30/18, at 6:28 p.m. R7 was sitting in the dining area, eating soup and sandwich without problems noted. When R7 completed his meal, he got up and walked back to his room, laid on his bed and placed a piece of tissue (Kleenex) into his mouth between his lower lip and gums. He was not wearing dentures and had no teeth. There was no drooling noted. Attempts to interview we not successful as R7 did not respond to the questions and turned his head away from surveyor. On 7/30/18, at 5:02 p.m. attempts were made to interview wife. There was no answer and no return call received. During an observation on 7/31/18, at 8:10 a.m. R7 was noted to be laying on his bed. He had three pieces of paper towel (like the type used in the bathroom) lined up on the bed. He had a piece tucked into his mouth and some sticking out the right side of his lower lip. There was no drooling noted. During an interview on 7/31/18, at 11:49 a.m. the licensed practical nurse (LPN)-A stated R7 has put tissue and paper in his mouth since	F 740	It is the policy of Central Heath Care to provide all our residents with behavioral Health Service to help them maintain their highest practical Physical, mental and psychosocial well-being. In accordance with their compressive assessment and Care plan. Residents #7 care plan was updated to reflect his current behavior. CNP also reviewed his current physical status and mental health needs on 8.1.18. Family was contacted and signed a HOLD Harmless Agreement on resident's behavior 8.1.18 Resident #7 care plan was revised, and Target Behaviors added on EMAR to monitor and document any adverse behavioral issues on 8.22.18 All residents care plans will be audited to reflect residents emotional and psychosocial well-being needs and Target Behaviors reviewed and updated to reflect current behavioral status. Audits of all residents who receive Psychoactive medications have current Target Behaviors in EMAR and updated to reflect current behaviors was completed on 8.22.18 Resident #7 has utilized Psychological services in the past (Deer Oaks), services ended in December after it was determined he was not benefiting from therapy. Facility had entered into a contract for tele-psych services offering more mental health services to our residents prior to		

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

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F 740	Continued From page 16 admission. LPN-A was aware of the facility having tried medication Scopolamine to reduce saliva but that did not work and was discontinued. LPN-A was aware of R7 having had psychological services in the past and explained R7 now was on Felons spray (medication for his sinuses). LPN-A also explained R7 has had different mouthwashes to use in the past including "bitten", and was not aware of any choking issues for R7. During an observation on 8/01/18, at 07:51 a.m. R7 was in his room, laying on his bed, eyes open, watching television, with a piece of tissue or paper tucked into his bottom lip. The paper was sticking out of his bottom lip, visible on observation. There was no drooling noted. During an observation on 08/02/18, at 09:26 a.m. R7 was on his bed, laying on his back, eyes closed with a piece of tissue is hanging out of right side of mouth. There was no drooling noted. Review of R7's electronic health record (HER) on 8/2/18, revealed: - A Dental Record dated 11/7/16, noted R7 did not wear dentures and had been on, "aspiration precautions". - An Oral Cavity Observation dated 5/17/17, indicated R7 "puts little pieces of Kleenex in his mouth D/T (due to) drooling, he tried the Scopolamine patch but it was ineffective." - The facility Oral Cavity Observations dated 8/14/17, 11/13/17, and 5/7/18, did not address R7 putting tissue or paper towel between his lower lip and gum or excessive drooling. - An Oral Cavity Observation dated 2/9/18, noted "He drools & uses little pieces of Kleenex to manage this as he has tried patches in the past to dry secretions but they were ineffective. He takes the Kleenex out any time he eats or drinks." - The Annual Minimum Data Assessment dated 11/22/17, included the care area assessments	F 740	Annual State Survey with their service starting on September 19,2018 Care Plan, medication use along with Target Behaviors will be completed on a weekly basis x4 than monthly or status changes. Results will be brought to the QAA meeting. Facility had implemented a Behavioral Inter-disiplinary Team which meets monthly to review resident's behaviors, medication use and Target Behaviors. The team will review all resident's medical records to ensure behavioral health care and services are met to promote their emotional and psychosocial well-being. Compliance Date: 9.7.18		

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

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F 740	Continued From page 17 (CAA) for Cognitive Loss/Dementia, Visual Function, Communication, Areas of Daily Living (ADLs) Functional Status, Rehabilitation Potential, Mood State, Behavioral Symptoms, Activities, Falls, Nutritional Status, Dental Care, Pressure Ulcers, and Psychotropic Medication Use. While the area of Behavior Symptoms CAA dated 11/22/17, addressed psychosis, hallucinations, depression and Alzheimer's as issues, the CAA's did not address R7's behavior of putting tissue or paper towel between his lower lip and gum or excessive drooling. - The EHR indicated R7 had been receiving services from the Deer Oaks; A Behavioral Health Organization. The Deer Oaks Psychological Services Progress Notes dated, 7/11/17, 8/15/17, and 10/3/17, indicated R7 had blunted affect, anxiety, depression, and he was engaged in the session. However services did not address putting tissue or paper towel between his lower lip and gum or excessive drooling. - A Mayo Clinic Health System in New Prague progress note dated 8/3/17, by a nurse practitioner (NP)-B noted "He does have a history of excessive salivation and he chews on paper towels or tissues." The note further indicated "He was sitting on his bed with multiple paper towels and Kleenex surrounding him. He did have some Kleenex in his mouth. Per staff he does this. He does not chew or swallow it, he just uses it to decrease the [mom] of salivation. He has been doing this for quite some time and has not had issues." Review of the NP-B notes dated 10/19/17, 12/13/17, 2/8/18, did not address putting tissue or paper towel between his lower lip and gum or excessive drooling. The nurse practitioner progress notes dated 4/4/18, did indicate, "He continues to have behaviors of stuffing Kleenex in his mouth. This has been	F 740			

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

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F 740	Continued From page 18 ongoing." The notes dated 6/18/18, and 7/16/18, did not address putting tissue or paper towel between his lower lip and gum or excessive drooling. - Review of the Care Plan Conference Summary notes dated 11/30/17, noted hallucinations, anxiety, no teeth or dentures per his choice, and mood as very pleasant. The note dated 2/27/18, addressed mild depression, no teeth or dentures, and having a mechanical soft diet without difficulty. A note dated 5/22/18, indicated R7 had some trouble sleeping and feeling down. None of the Care Plan Conference Summary notes addressed putting tissue or paper towel between his lower lip and gum or excessive drooling. - Review of the electronic health record for May, June and July 2018, indicated R7 was monitored for target behaviors for agitation, delusions that the "Virgin Mary" was telling him things, and refused to allow staff to assist with ADLs. R7 was monitored for the effects and side effects of blood thinners, anti-depressant and anti-psychotic medication use. However R7 was not monitored for putting tissue or paper towel between his lower lip and gum or excessive drooling. - A review of the multidisciplinary progress notes (to include the quarterly care conference progress notes dated 5/8/18 through 7/30/18, did not address or mention putting tissue or paper towel between his lower lip and gum or excessive drooling. - R7's care plan dated 5/11/18, did not address putting tissue or paper towel between his lower lip and gum or excessive drooling. - Pharmacy notes dated 2/16/18 through 7/13/18, indicated R7 was on medication for depression, psychosis and sleep, and all were stable. R7 had a dose reduction in risperidone (for his psychosis) on 4/13/18, per the recommendation of the	F 740			

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

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F 740	Continued From page 19 pharmacist, and a dose reduction of the trazadone (antidepressant medication) on 6/12/18, was declined as they felt it would increase his hallucination and verbalizations of "Mother Mary." The pharmacy notes did not address behavior of putting tissue or paper towel between his lower lip and gum or excessive drooling. - The "Monthly Mood/Behavior Flowsheets" for R7 dated: May, June, and July 2018 did not indicate any behavior monitoring for resident behavior of putting tissue or paper towel between his lower lip and gum or excessive drooling. During an interview on 07/31/18, at 11:57 a.m. the director of nursing (DON) stated the resident had dementia and hallucinations. DON explained the Kleenex in R7's mouth was a constant behavior, the use of scopolamine created more psychosis and he had to have the scopolamine discontinued on 4/19/17. DON was not able to find evidence of drooling or use of Kleenex in the care plan. She was also not able to find any behavior monitoring related to drooling or use of Kleenex in his mouth in R7's medical record. During an interview on 8/01/18, at 9:29 a.m. registered nurse (RN)-B, stated R7 was not drooling, she knew the facility tried a patch for excess saliva and did not work. RN-B stated that she was not aware of R7 or his family been informed of risks or benefits related to keeping these products in his mouth. At 1:23 p.m. RN-B reviewed the electronic medical record and could not locate assessments, Minimum Data Set (MDS) assessments, care area assessments (CAA), behavior monitoring or target behaviors that addressed R7's drooling or the use of Kleenex in his mouth. During an interview on 8/01/18, at 1:04 p.m. the nurse practitioner (NP)-A, stated she had noticed	F 740			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 740	Continued From page 20 R7 had Kleenex in his mouth during one visit, but did not know the history and could not address this. During an interview on 8/01/18, at 1:42 p.m. the dietary manager (DM) stated she had not assessed R7's drooling and/or the use of paper in his mouth. DM also stated R7 was able to feed self, has not had weight loss, could tell the staff what he wanted, and was not at choking risk. A policy provided by the facility Procedure 565, Resident Assessment: CARE PLAN DOCUMENTATION GUIDELINES indicated: "Identify the resident's problems and strengths. Consider listing possible risks and complications." The approaches included: "Identify problems noted on resident assessment", "The underlying cause of problems should be investigated for maximum effectiveness of care planning" and "Develop a coordinated plan to produce appropriate care for each problem identified."	F 740			
F 812 SS=F	Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812			8/24/18

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 812	Continued From page 21 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain the kitchen ice machine clean and sanitary in order to prevent potential contamination. This deficient practice had the potential to affect all 27 residents who resided in the facility. Findings include: On 7/30/18, at 1:30 p.m. a kitchen tour was conducted with the director of nursing (DON). When entered the room where the ice machine was stored the sliding cover was open exposing the ice to the room air. The three foot long drainage tubing from the ice machine was inserted into an open pipe coming out of the floor. The drainage tubing contained a six inch area of black moist substance build up at both ends and speckled black spots along the entire middle section. The tubing was clear, flexible plastic tubing and had been inserted into a drain tube along with other drainage tubing. At 1:35 p.m. DON stated the ice machine cover should never be left open and confirmed there was black moist substance throughout the ice machine drainage tube. DON further stated she would contact the maintenance supervisor (MS) right away so he could look at it. On 7/30/18, at 1:40 p.m. the MS was brought to the ice machine room and stated he had never noticed the black substance in the drainage tube before and it could be occluded and he would	F 812	F812 ☐ Food Procurement, Store/Prepare/Serve-Sanitary CFR(s):483.60(i)(1)(2) It is the policy of Central Health Care to monitor and maintain the kitchen ice machine to ensure it is clean and sanitary to prevent potential contamination. It is also the policy of Central Health Care that the kitchen ice machine access door be shut when not in use to prevent contamination. The Maintenance Director does routinely clean and maintain the kitchen ice machine. The Maintenance Director reviewed the manufactures directions related to the drainage tube and did immediately replace the clear tubing with the recommended black rigid tubing. The drain is routed separately into the drain and will be inspected during routine preventive maintenance environmental tours monthly. To ensure that the kitchen ice machine access door is closed when not in use, visible signage has been placed on the ice machine as a reminder to ensure the access door is closed after use. Staff will be re-educated on the appropriate procedure for using the kitchen ice machine. To ensure continued		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 812	Continued From page 22 investigate it. The MS further stated the black moist substance in the tubing should not be there and all parts of the ice machine should have been cleaned and maintained every three months. The Scotsman model CU1526 ice machine installation and user manual dated 5/2008, was reviewed and directed installers to use rigid drain tubes, route them separately and to not Tee them into the bin's drain. On 07/31/18 at 8:10 a.m. the MS stated the ice machine should not have had a clear plastic drain tube with a bend in it and should have a non-flexible drain tube. MS further stated clear tubing could possible allow mold to grow and he would change the tubing right away. MS also stated the manufacturer's instructions indicated it should have been installed with a non-flexible drain tube and that had not been done. On 8/1/18, the administrator stated his expectations would be for maintenance to follow manufacturer's instructions with all installations and to follow up with recommended routine maintenance. The administrator further stated the MS was putting the proper drain tubing on the ice machine and the cover should have never been left open. A facility policy regarding ice machine maintenance was requested and none was provided.	F 812	compliance, checking the ice machine will be part of the weekly/monthly environmental tours that will be conducted and monitored by the Maintenance Director or designee. The Maintenance Director or designee will present any concerns in the daily/weekly IDT meeting. The environmental tracking log information will be reviewed at the quarterly QAPI committee meeting. Compliance Date: 09/07/2018		
F 836 SS=F	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State	F 836		8/24/18	

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

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F 836	Continued From page 23 and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the supplemental nursing service agency (SNSA) utilized by the facility was registered with the Minnesota commissioner, as required. This had the potential to affect approximately all 27 residents who received services from the supplemental staff.	F 836	F836 Licensure/Professional Standards It is the policy of Central Health Care to ensure that all employees providing care to our residents meet professional standards according to their licensure status. It is our policy to ensure that every		

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F 836	Continued From page 24 Findings include: During the entrance conference on 7/30/18, at 2:00 p.m. the director of nursing (DON) stated the facility utilized One Staff Medical staffing agency to provide nursing coverage. On 7/31/18, at 1:37 p.m. it was confirmed that One Staff Medical was not listed as a currently registered SNSA on the State of Minnesota's approved SNSA list. On 8/31/18, at 4:15 p.m. DON and staffing coordinator confirmed that staff from this pool had been removed from the schedule effective 7/31/18. They also confirmed that pool nurse (PN)-A, had worked on 7/17/18, 7/18/18, 7/19/18, and 7/25/18, from 2:00 p.m. to 10:30 p.m. and also worked on 7/23/18, 7/24/18, 7/27/17, 7/28/18, 7/29/18, from 2:00 p.m. to 6:30 a.m. (double shifts). PN-A provided cares to residents and was the only nurse in the building on the over night shifts worked. DON stated she checked the registry every few months to assure the staffing agencies were listed and it had been a few months since she had last check. Communication from a health program representative at the Minnesota Department of Health on 7/31/18, indicated that One Staff Medical had not been licensed and registered since they had relocated on 7/16/18.	F 836	person staffed in the facility has a current licensure as we provide nursing services 24/7. Both individuals working through the SNSA did hold a current licensure and was in good standing. Currently the facility utilizes 2 staffing agencies to supplement our nursing staff. One Staff Medical employees were removed from the schedule as soon as it was determined the company was not authorized in the State of Minnesota. The second company, AnnLeo, has verified with the facility that they check the State Registry daily to verify company status before sending any employee to provide care. One Staff Medical did renew their company information-including the address change and is authorized to provide employees in the State of Minnesota. Facility has implemented a Policy and Procedure to verify on a weekly basis the status of One Staff Medical that services can be provided to the facility. Confirmation will be printed off and will be presented to the IDT on a weekly basis by the Director of Nursing or designee with results presented to the QAA meetings. Compliance date: 8.20.18		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for	F 921		8/24/18	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 921	Continued From page 25 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a clean and maintained environment for 2 of 3 hallways related to cleanliness of vents, light fixtures and linen closets. This deficient practice had the potential to affect all 27 residents in the facility. Findings include: On 8/02/18, at 8:37 a.m., an environmental tour of the facility was completed with the maintenance supervisor (MS). There were three vents on the south wing ceiling that had dust and dark colored substance on them. MS stood on a chair and wiped visible dirt off with his hand. MS stated that he cleaned the vents twice a year, one time in the fall when he put insulation in them and in the spring when he removed the insulation. MS further stated that housekeeping should have been dusting and cleaning these regularly. On the north wing, there were six ceiling light fixtures with visible dirt inside the lens covers. MS explained staff would clean these when the bulbs went out or if the fixture needed to be replaced, and housekeeping should be cleaning light fixtures. On the south wing, in a linen closet, there were approximately 13 comforters (blankets) piled on the floor between the shelves. MS stated that he did not think these were being used, but should have not been stored on the floor. When asked about preventative maintenance, MS stated that he did walk through's, knew what needed to be done and would get things done. MS also stated that he did not have an approach to tracking some items.	F 921	F921 ☐ Safe/Functional/Sanitary/Comfortable Environment CFR(s): 483.90(i) It is the policy of Central Health Care to provide a clean and maintained environment. The policy also addresses that linen is to be stored off the ground to ensure linen stays clean. The housekeeping department does provide facility cleaning daily to ensure the facility is clean and well maintained. Housekeeping did clean the three vents in the south wing and have been reminded to monitor all vents daily to ensure continued compliance. All linen storage closets have been audited to ensure no other line was placed on the ground. No other linen closet had line stored on the ground. The Housekeeping/Laundry Supervisor or designee will conduct facility environmental tours to audit and ensure the facility is clean and well maintained. To ensure continued compliance, the facility, including storage areas will be part of the weekly/monthly environmental tours that will be conducted and monitored by the Housekeeping/Laundry Supervisor or designee. The Housekeeping/Laundry Supervisor or designee will present any concerns in the daily/weekly IDT meeting. The environmental tracking log information will be reviewed at the		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/02/2018
NAME OF PROVIDER OR SUPPLIER CENTRAL HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 444 NORTH CORDOVA LE CENTER, MN 56057		
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F 921	Continued From page 26 On 8/02/18, at 8:59 a.m. the housekeeping director (HD) verified the dirty light fixtures, vents and pile of comforters on the floor in the south linen room. HD stated that maintenance staff were responsible for the vents and light fixtures. HD also stated that linen should never be placed or stored on the floor and would take actions to correct this immediately. On 8/02/18, at 10:43 a.m. the director of nursing (DON) stated staff should never store linen on the floor. Requests for documents for preventative maintenance and cleaning were requested. Blank documents titled, Preventative Maintenance Log-Resident Unit were reviewed, which addressed the preventative maintenance of the resident rooms. The job description for "housekeeper" was also provided for review and indicated "Dust room and halls". No other policies were provided for review.	F 921	quarterly QAPI committee meeting. Compliance Date: 09/07/2018		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER CENTRAL HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 444 NORTH CORDOVA LE CENTER, MN 56057		
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Central Health Care was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000			

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/24/2018

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

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> 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. Central Health Care is a 1-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1966 and was determined to be of Type II(111) construction. In 1969, an addition was constructed and was determined to be of Type II(111) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkled. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification.	K 000			

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K 000	Continued From page 2	K 000			
K 345 SS=E	The facility has a capacity of 40 beds and had a census of 28 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to test and maintain the Fire Alarm System in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. This deficient practice could effect 28 of 28 residents. Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25.	K 345	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. Submission of this plan of correction is not an admission that the deficiency existed or that it is cited accurately. This plan of correction is submitted to meet state and federal requirements. K345 ☐ Fire Alarm System ☐ Testing and Maintenance CFR(s): NFPA 101 It is the policy of Central Health Care to test and maintain the Fire Alarm System in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of the system acceptance, maintenance and testing are in a secure location and readily	8/24/18	

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

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K 345	Continued From page 3 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 07/31/2018, during documentation review, documentation could not be located to show that the smoke detector sensitivity inspection had occurred with the last 2 years. This deficient practice was verified by the Facility Maintenance Director.	K 345	available. Central Health Care had First Choice Fire Alarm conduct a smoke detector sensitivity inspection on 08/06/2018. To ensure ongoing compliance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code, Central Health Care has developed a calendar tracking system which is monitored and maintained by the Maintenance Director or designee. The Safety Committee will monitor and review monthly to ensure required inspections and testing is completed in a timely manner. Central Health Care has also pre-scheduled the smoke detector sensitivity inspections with First Choice Fire Alarm to occur on a 2-year recurring bases. All records of the inspections are maintained and readily available. The Maintenance Director has been re-educated on the testing/inspection frequency required for NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code related to sensitivity testing on the smoke detector system. The Maintenance Director or designee will monitor monthly required inspections and testing to prevent a reoccurrence of this deficiency to ensure continued compliance is maintained. Compliance Date: 08/31/2018	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		8/24/18

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

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K 353	Continued From page 4 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain the automatic sprinkler system in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice could affect 28 out of 28 residents. Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____	K 353	K353 ☐ Sprinkler System ☐ Maintenance and Testing CFR(s): NFPA 101 It is the policy of Central Health Care to test and maintain the automatic sprinkler system in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA 25. It is also the policy of Central Health Care to maintain records of system design, maintenance, inspection and testing in a secure location and readily available. Central Health Care had Olympic Fire Sprinkler conduct a quarterly fire sprinkler inspection on 08/13/2018. To ensure ongoing compliance with the automatic sprinkler system in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA 25, Central Health	

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K 353	Continued From page 5 b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 07/31/2018, during documentation review, documentation could not be provided to show that a quarterly fire sprinkler inspection occurred during the past year. This deficient practice was verified by the Facility Maintenance Director.	K 353	Care has developed a calendar tracking system which is monitored and maintained by the Maintenance Director or designee. The Safety Committee will monitor and review monthly to ensure required inspections and testing is completed in a timely manner. The Maintenance Director has been re-educated on the testing/inspection frequency required with 9.7.5, 9.7.7, 9.7.8, and NFPA 25 regulations. The Maintenance Director or designee will monitor monthly required inspections and testing to prevent a reoccurrence of this deficiency to ensure continued compliance is maintained. Compliance Date: 08/31/2018		
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test	K 918		8/24/18	

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

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K 918	Continued From page 6 under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide complete written records of generator maintenance and testing. This deficient practice could affect 28 of 28 residents. Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised	K 918	K918 ☐ Electrical Systems ☐ Essential Electrical System CFR(s): NFPA 101 It is the policy of Central Health Care to test and maintain Essential Electric Systems in accordance with 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70). It is also the policy of Central Health Care to maintain written records of maintenance/testing related to Essential Electric Systems and ensure those records are readily available. Central Health Care had Generator System Services Inc. conduct an annual generator maintenance, inspection and testing on 08/23/2018. To ensure ongoing compliance with testing and maintaining		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 918	Continued From page 7 under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 07/31/2018, during documentation review, it was revealed that documentation could not be located to show that annual maintenance had occurred on the emergency generator. This deficient practice was verified by the Facility Maintenance Director.	K 918	Essential Electric Systems (emergency generator), Central Health Care has developed a calendar tracking system which is monitored and maintained by the Maintenance Director or designee. The Safety Committee will monitor and review monthly to ensure required inspections and testing is completed in a timely manner. The Maintenance Director has been re-educated on the testing/inspection frequency required with 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70). The Maintenance Director or designee will monitor monthly required inspections, maintenance, and testing to prevent a reoccurrence of this deficiency to ensure continued compliance is maintained. Compliance Date: 08/31/2018		