

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EM46

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00284

1. MEDICARE/MEDICAID PROVIDER NO. (L1) <b>245389</b>  2. STATE VENDOR OR MEDICAID NO. (L2) <b>695723400</b>  5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)  6. DATE OF SURVEY <b>10/27/2017</b> (L34)  8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	3. NAME AND ADDRESS OF FACILITY (L3) <b>LANGTON PLACE</b> (L4) <b>1910 WEST COUNTY ROAD D</b> (L5) <b>ROSEVILLE, MN</b> (L6) <b>55112</b>  7. PROVIDER/SUPPLIER CATEGORY (L7) <u>04</u> <b>01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA</b> <b>02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF</b> <b>03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC</b> <b>04 SNF 08 OPT/SP 12 RHC 16 HOSPICE</b>	4. TYPE OF ACTION: <u>7</u> (L8)  <b>1. Initial 2. Recertification</b> <b>3. Termination 4. CHOW</b> <b>5. Validation 6. Complaint</b> <b>7. On-Site Visit 9. Other</b> <b>8. Full Survey After Complaint</b>  FISCAL YEAR ENDING DATE: (L35)  <b>09/30</b>															
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :  12. Total Facility Beds <b>94</b> (L18) 13. Total Certified Beds <b>94</b> (L17)	10. THE FACILITY IS CERTIFIED AS: <b>X</b> 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  B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: <b>A</b> (L12)																
14. LTC CERTIFIED BED BREAKDOWN <table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">18 SNF</td> <td style="text-align: center;">18/19 SNF</td> <td style="text-align: center;">19 SNF</td> <td style="text-align: center;">ICF</td> <td style="text-align: center;">IID</td> </tr> <tr> <td style="text-align: center;">94</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">(L37)</td> <td style="text-align: center;">(L38)</td> <td style="text-align: center;">(L39)</td> <td style="text-align: center;">(L42)</td> <td style="text-align: center;">(L43)</td> </tr> </table>	18 SNF	18/19 SNF	19 SNF	ICF	IID	94					(L37)	(L38)	(L39)	(L42)	(L43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)	
18 SNF	18/19 SNF	19 SNF	ICF	IID													
94																	
(L37)	(L38)	(L39)	(L42)	(L43)													

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

17. SURVEYOR SIGNATURE  <u>Susanne Reuss, Unit Supervisor</u> Date : 05/21/2018 (L19)	18. STATE SURVEY AGENCY APPROVAL  <u>Joanne Simon, Enforcement Specialist</u> 05/21/2018 (L20)
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY <input checked="" type="checkbox"/> 1. Facility is Eligible to Participate <input type="checkbox"/> 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 <b>12/01/1986</b> (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)	
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO. <b>03001</b> (L28) (L31)	26. TERMINATION ACTION: (L30) <u>VOLUNTARY</u> <b>00</b> <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
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE <b>09/29/2017</b> (L33)	
DETERMINATION APPROVAL		

CMS Certification Number (CCN): 245389

May 21, 2018

Mr. Mathew Bedard, Administrator  
Langton Place  
1910 West County Road D  
Roseville, MN 55112

Dear Mr. Bedard:

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 program.

Effective July 20, 2017 the above facility is recommended for:

94 Skilled Nursing Facility Beds

Your facility's Medicare approved area consists of all 94 skilled nursing facility beds located in rooms .

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

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

Please contact me if you have any questions.

Sincerely,



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

cc: Licensing and Certification File



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
May 21, 2018

Mr. Mathew Bedard, Administrator  
Langton Place  
1910 West County Road D  
Roseville, MN 55112

RE: Project Number S5389026

Dear Mr. Bedard:

On August 8, 2017 we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 20, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constitute no actual harm with potential for no more than minimal harm (Level C) whereby corrections were required.

October 27, 2017 the Minnesota Department of Public Safety completed a PCR by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 20, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 20, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 20, 2017, effective July 20, 2017 and therefore remedies outlined in our letter to you dated August 8, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

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

cc: Licensing and Certification File

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: EM46

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00284

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6. DATE OF SURVEY <b>07/20/2017</b> (L34)		7. PROVIDER/SUPPLIER CATEGORY <u>04</u> (L7) <b>01 Hospital</b> <b>05 HHA</b> <b>09 ESRD</b> <b>13 PTIP</b> <b>22 CLIA</b> <b>02 SNF/NF/Dual</b> <b>06 PRTF</b> <b>10 NF</b> <b>14 CORF</b> <b>03 SNF/NF/Distinct</b> <b>07 X-Ray</b> <b>11 ICF/IID</b> <b>15 ASC</b> <b>04 SNF</b> <b>08 OPT/SP</b> <b>12 RHC</b> <b>16 HOSPICE</b>				
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11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		12. Total Facility Beds <b>94</b> (L18) 13. Total Certified Beds <b>94</b> (L17)				
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID <b>94</b> (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 <b>Susan Miller, HFE NE II</b> (L19)		Date : <b>08/20/2017</b>	18. STATE SURVEY AGENCY APPROVAL <b>Kate JohnsTon, Program Specialist</b> (L20)		Date: <b>09/29/2017</b>
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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 : _____	
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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:		29. INTERMEDIARY/CARRIER NO. <b>03001</b> (L28) (L31)		30. REMARKS  Posted 09/29/2017 Co.  DETERMINATION APPROVAL	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)			



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Delivered  
August 8, 2017

Mr. Mathew Bedard, Administrator  
Langton Place  
1910 West County Road D  
Roseville, MN 55112

RE: Project Number S5389026

Dear Mr. Bedard:

On July 20, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for no more than minimal harm (Level C), as evidenced by the electronically delivered 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:

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

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

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

## DEPARTMENT CONTACT

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

**Susanne Reuss, Unit Supervisor**  
**Metro A 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: susanne.reuss@state.mn.us**  
**Phone: (651) 201-3793**  
**Fax: (651) 215-9697**

## PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

#### **PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

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

#### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

Upon receipt of an acceptable POC, a revisit of a facility may be conducted to verify that compliance with the regulations has been attained. If a revisit is conducted, it will occur after the date you identified that compliance was achieved in your plan of correction.

#### **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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: [http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\\_idr.cfm](http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm)

Langton Place  
August 7, 2017  
Page 4

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,



Kate JohnsTon, Program Specialist  
Program Assurance Unit  
Licensing and Certification Program  
Health Regulation Division  
Minnesota Department of Health  
kate.johnston@state.mn.us  
Telephone: (651) 201-3992 Fax: (651) 215-9697



cc: Licensing and Certification File



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

PRINTED: 08/04/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/20/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>LANGTON PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  On July 17, 18, 19 and 20, 2017, surveyors of this department conducted a recertification survey. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	F 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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

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

F5389026

PRINTED: 08/21/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/20/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>LANGTON PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	<p><b>INITIAL COMMENTS</b></p> <p><b>FIRE SAFETY</b></p> <p>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Langton Place was found to be <b>NOT</b> 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.</p> <p>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.</p> <p>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.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145</p>	K 000			



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
**Electronically Signed**

TITLE

(X6) DATE  
**08/15/2017**

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

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

PRINTED: 08/21/2017  
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NAME OF PROVIDER OR SUPPLIER  <b>LANGTON PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Or by email to: Angela.Kappenman@state.mn.usand Marian.Whitney@state.mn.us  THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:  1. A description of what has been, or will be, done to correct the deficiency.  2. The actual, or proposed, completion date.  3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.  This 2-story building was determined to be of Type II(222) construction. It has a partial basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 94 beds and had a census of 78 beds at the time of the survey.	K 000		
K 353 SS=C	NFPA 101 Sprinkler System - Maintenance and Testing  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire	K 353		8/31/17

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245389</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>07/20/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>LANGTON PLACE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1910 WEST COUNTY ROAD D ROSEVILLE, MN 55112</b>		
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K 353	Continued From page 2 Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked  b) Who provided system test  c) Water system supply source  Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and document review, the facility did not maintain and test their automatic fire sprinkler system in accordance with NFPA 25 and the 2012 LSC NFPA 101. 9.7.5, 9.7.7, 9.7.8. This deficient practice could effect all 57 residents.  Findings include:  On a facility tour between the hours of 0800 and 1200 on July 20, 2017, observation revealed that a sprinkler head maintenance room 4 had been painted over to include the fusible link.  This deficient practice was verified by the director of environmental services at the time of inspection.	K 353	The fire sprinkler system annual inspection will be completed according to the requirements of NFPA 25 (11) and NFPA 101 (12) Section 9. As part of this annual inspection, all fire sprinkler heads will be visually observed to ensure they are intact and in good working condition including verifying there is no paint or other substance on the head that would impair its performance. This inspection will be done by a licensed fire sprinkler maintenance company and will be directed by the Environmental Services Director. (ESD) The ESD will be responsible for ensuring that all heads are inspected and replaced if necessary. The sprinkler head that was found to be faulty will be replaced by August 31st, 2017		
K 712 SS=C	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire	K 712		8/31/17	

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K 712	Continued From page 3 conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Base on review of records and staff interview, it was determined that the facility failed to vary the times of fire drills for one shift in accordance with NFPA 101 LSC (12) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 94 residents.  Findings include:  On facility tour between 0800 and 1200 on 07/20/2017, a review of the available fire drill reports revealed that the facility failed to vary all fire drills for all shifts in the last year.  This deficient practice was confirmed by the Director of Maintenance (BC).	K 712	Fire drills will be conducted according to NFPA 101 (12) Section 18 and 19. Fire drills will be held at unexpected times and under varying conditions, at least quarterly on each shift. Per NFPA 101 (12) Section 19.7.1.2, and on the instruction of the state fire marshal, at least 90 minutes difference between scheduled quarterly fire drill start times will be maintained. Fire drills will be scheduled into the electronic work order system by the Environmental Services Director (ESD) and the ESD will be responsible to schedule the fire drill timing according to the code requirements. The Safety Committee will review all fire drill reports for accuracy. Scheduling the fire drills into the work order system will be done by August 31st, 2017	
K 923 SS=C	NFPA 101 Gas Equipment - Cylinder and Container Storage  Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and	K 923		8/31/17

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K 923	Continued From page 4 ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, that the facility did not properly store oxygen cylinders in accordance with NFPA 99. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5. This deficient practice could affect 65 of 94 residents.	K 923	All oxygen storage will comply with the requirements of NFPA 99 (12) section 11. The oxygen storage rooms will have separate storage racks for FULL and EMPTY oxygen cylinders. The		

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K 923	Continued From page 5  Findings include:  On a facility tour between the hours of 0800 and 1200 on Jul 20, 2017, observation revealed that oxygen cylinders were being stored intermingled and not separated empty vs full in the oxygen storage room in the first and second floor oxygen storage rooms.  This deficient practice was verified by the Director of Environmental Services at the time of inspection.	K 923	Environmental Services Director (ESD) will be responsible for ensuring that oxygen cylinders are separated by FULL and EMPTY in the racks. The oxygen cylinders in all oxygen storage rooms will be separated into distinct racks labeled FULL and EMPTY by August 31st, 2017		